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The Challenge of Managing Across Boundaries: The Case of the Office of the Secretary in the U.S. Department of Health and Human Services

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The PricewaterhouseCoopers Endowment for
The Business of Government

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Foreword

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On behalf of The PricewaterhouseCoopers Endowment for The Business of Government, we are pleased to present this report by Beryl A. Radin, "The Challenge of Managing Across Boundaries: The Case of the Office of the Secretary in the U.S. Department of Health and Human Services." The report provides further insights by Professor Radin on the organization and management of the Department of Health and Human Services (HHS) under Secretary Donna Shalala. In 1999, the Endowment issued Professor Radin's first report on HHS, "Managing Decentralized Departments."

In this report, Professor Radin presents seven case studies of how one cabinet department — the United States Department of Health and Human Services — effectively used a portfolio of crosscutting mechanisms to address specific issues or problems facing the department. In the past, federal departments and agencies had a tendency to either reorganize or create new central offices to address problems. Professor Radin argues that in the 21st century, contemporary organizations will have to find new organizational mechanisms to address constantly arising crosscutting issues and problems. The movement toward flatter, less hierarchical organizations will require new ways to share responsibility and jointly problem-solve within organizations. Professor Radin highlights four types of innovative crosscutting mechanisms that organizations can use, rather than relying on more traditional approaches.

We hope that this report will be helpful to the new administration as each new cabinet secretary and agency head begins the challenging task of organizing his or her department or agency. While it might prove tempting to reorganize or create new offices, Professor Radin presents innovative ways that organizations can work together collegially and effectively in responding to challenges and issues.

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Executive Summary

While some degree of complexity and uncertainty has characterized federal organizations over their history, the extent of this complexity has increased over the past decade. This creates a real challenge for a new Secretary of a cabinet department. Most recently, the determination to flatten organizations, reduce hierarchies, and devolve responsibilities for implementation of programs to others has contributed to this situation. As a result, the techniques and approaches that have been used in the past to manage large public organizations require rethinking.

Thus, to continue to rely on the traditional modes of achieving a corporate identity in large-scale federal agencies seems foolhardy. While the traditional strategies have not been completely rejected, an array of new approaches have been developed as alternative ways of managing these structures. Rather than emphasizing structural centralization or command-and-control strategies, these approaches have sought to find a way to define a role for top management in the context of decentralized, flat, and devolved organizations. While the majority of the energy and work of these organizations is done in the decentralized units, there are times when it is important to find a way for the top management to become involved in activities, playing a coordination or crosscutting role. Some of the techniques that have been employed are not new, but because they are used in a context that is quite different from management in the past, they take on a different meaning.

A number of examples have emerged from the Department of Health and Human Services (HHS) that illustrate a modified way of managing a very large federal department. Some of these examples illustrate efforts at institutionalizing processes that respect the autonomy of the decentralized units but, at the same time, provide a role for the Office of the Secretary and the top management of the department. Still other examples reflect specific policy or program issues that require the department to play a role, either because of external pressure or because of conflicts between approaches taken by units within the department.

The seven case studies that have been included in this analysis highlight four types of crosscutting mechanisms:

- mechanisms for problem solving;
- mechanisms for coordination;
- mechanisms for information sharing/team building; and
- processes to balance bottom-up and department-wide perspectives.

The case studies include:

- the role of the Office of the Secretary in improving human subjects protection;
- strategies for addressing racial and health disparities;

- the HHS Data Council;
- preparation for Y2K;
- Management Issues Lunches;
- the Budget Review Board; and
- the Government Performance and Results Act process.

These examples indicate that it is possible to devise ways for the Office of the Secretary to become involved in the department's decision process without resorting to command-and-control approaches. The roles that are illustrated include:

- seeking long-term solutions;
- broadening an issue;
- serving as a facilitator;
- encouraging bottom-up efforts; and
- translating technical issues to generalist language.

Care must be taken in the way that program units are treated; they must be respected, not tolerated. The examples of crosscutting and coordinating mechanisms that have been presented suggest that these new approaches to management within the Office of the Secretary must be devised with modest expectations. Not all areas are appropriate for an active Office of the Secretary role, and it is important to work hard to avoid preempting the program units. At the same time, these approaches do provide a way for the Office of the Secretary to add value. It creates a set of roles in an agency that is diverse that allows it to develop a corporate identity where the whole is greater than the sum of the parts.

Introduction

Background

Public organizations that are in operation at the beginning of the 21st century exhibit characteristics that are quite different from those organizations that were found during most of the 20th century. A snapshot of such organizations — particularly those operating at the federal government level — provides a picture that is without a clear visual focus. It is often difficult to ascertain which aspects of the organization are in the foreground of the picture and which aspects are in the background.

This creates a real challenge for a new Secretary of a cabinet department. Not only are these organizations extremely complex, but they are increasingly charged with the implementation of a variety of policies and programs, employing a range of instruments to carry out those programs. Increasingly federal organizations do not actually carry out the service delivery function themselves but, rather, rely on others (both actors in other levels of the public sector as well as those in the private and nonprofit sectors) to carry out the mission of the organization. The combination of complexity and involvement of others creates a sense of increased uncertainty for top managers, who must respond to constantly changing circumstances.

The ambiguity and conflict that is a characteristic of contemporary organizations is often masked by their formal structures. While specialized units have been brought together under a common umbrella or framework, one needs simply to scratch the surface of those organizations to recognize that it is often illusory to think of those umbrellas as an accurate way of describing what actually goes on within the organizational structure.

Mechanisms are required that allow a cabinet official to be able to act relatively quickly to new problems, to avoid establishing management processes for their own sakes, to focus strategically on a specific set of policy or program goals, and to deal with a variety of actors both inside and outside the department. In addition, the cabinet Secretary often needs to develop procedures that are time limited and crafted to deal with a specific issue.

While some degree of complexity has characterized federal organizations over their history (and formal structures have never really described what happens inside an organization), the extent of this complexity has increased over the past decade. Most recently, the determination to flatten organizations, reduce hierarchies, and devolve responsibilities for implementation of programs to others has contributed to this situation. As a result, the techniques and approaches that have been used in the past to manage large public organizations require rethinking.

In the past, management of these organizations relied on two major approaches: tinkering with organizational structure and adopting centralized processes as control mechanisms.

Changes in Organizational Structure

Modifications to the organizational structure have traditionally been used as a way of linking pro-

grams or units together or to limit the autonomy of specific units. The reorganizations that emerge from this strategy provide a mechanism for those charged with the management responsibility within a large umbrella agency to minimize fragmentation and establish consistencies across program units. The assumption has been that centralization will solve most problems.

Although some reorganization efforts have been openly devised as methods of controlling what are viewed as maverick or runaway agencies, most of these efforts have been promoted on the basis of increasing efficiency or providing approaches that would achieve policy or program effectiveness. In addition, agencies are constrained by Congress in their ability to make major changes in structure solely on management grounds.

Centralized Management Processes

Traditionally a series of internal management processes have been used to highlight consistencies and efficiencies within large agencies composed of multiple and diffuse units. The budget process is most commonly used to play this role, providing a way for the top offices of a department or large agency to establish command-and-control mechanisms that minimize the autonomy of units in their search for fiscal resources. Units have usually come to centralized budget offices as supplicants for those resources. Similarly, both the personnel process and the acquisition process have been employed to achieve this purpose, providing mechanisms in which a centralized unit in the large organization plays a controlling role, limiting the discretion of the smaller units. Over the years, the growth of staff units within the top reaches of federal agencies has been a response to this urge.

By the end of the 20th century, however, the limitations of both of these strategies have been acknowledged by many who have responsibility for federal management reform. The various efforts that have been associated with the reinvention movement (the National Performance Review and other reform efforts) have moved the pendulum away from reform that increased centralization and emphasized a command-and-control approach to management. As Osborne and Gaebler have described it, organizations have adopted the "steer, not row" approach to management.[1]

Increasingly, those who have employed structural reorganization strategies recognize that these efforts may have less to do with substantive achievements than with symbolic action. Moving a unit around within a larger organizational framework may have little impact on the way that the unit actually does its work. Similarly, the attempt to manage large-scale federal organizations through centralized units has neither been very effective nor has it comported with the fragmented decision-making process that characterizes the American political system. While the press and some legislative critics focus on the role of the Secretary or the top organizational leader in an agency, decisions related to resources (particularly the budget) and legislative authority are made in the context of the specialized units within the umbrella organization. At the same time, there are times when some centralization of specific functions is the only effective way to address problems.

Thus, in this context, to continue to rely on the traditional modes of achieving a corporate identity in large-scale federal agencies seems to be foolhardy. While these strategies have not been completely rejected, an array of new approaches have been developed as alternative ways of managing these structures. The tools available to deal with these issues usually lie within the Office of the Secretary of a department — that is, in the staff rather than line components of the department. Some of the techniques that have been employed are not new but, because they are used in a context of decentralization, take on a different meaning than they did in the past.

Rather than emphasizing structural centralization or command-and-control strategies, these approaches have sought to find a way to define a role for top management in the context of decentralized, flat, and devolved organizations. While the majority of the energy and work of these organizations is done in the decentralized units, there are times when it

[1] *David Osborne and Ted Gaebler,* Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector *(Reading, MA: Addison-Wesley Publishing Company, 1992).*

is important to find a way for the top management to become involved in activities, playing a coordination or crosscutting role.

The HHS Experience

Since its creation in 1953 as an amalgam of several existing agencies, the U.S. Department of Health and Human Services (originally the Department of Health, Education and Welfare) has struggled with the appropriate balance between centralized functions in the Office of the Secretary and autonomy to the various agencies and bureaus contained within its boundaries. Over the years, the pendulum has swung back and forth between emphasis on centralization and decentralization as either implicit or explicit management strategies.[2]

The current Secretary, Donna Shalala, has adopted a conscious management strategy that is very different from those attempted in the past. She began with the assumption that the department contains many decentralized elements and that change has to be self-generated within those elements to be effective. She describes the department as composed of units that have their own history, needs, cultures, and constituencies. She has used the professional credibility of the subunits within the office (especially those dealing with the health world) as an important source of public and political support. She has downsized the Office of the Secretary and delegated many different functions to the operating components. At the same time, she believes that the Office of the Secretary can play a leadership role in stimulating change in the submits.

The reorganization that accompanied the movement of the Social Security Administration (SSA) out of HHS in 1995, halving the department's staff and budget, reinforced the Secretary's own style. The structure that was devised created a flat organizational structure, which represented the Secretary's personal management view. These efforts coincided with the activities of the Vice President's National Performance Review, which advocated flat organizations built around efforts to empower line officials.

A number of examples have emerged from this management style that illustrate a modified way of managing a very large federal department. Some of these examples illustrate efforts at institutionalizing processes that both respect the autonomy of the decentralized units but, at the same time, provide a role for the Office of the Secretary and the top management of the department. Still other examples reflect specific policy or program issues that require the department to play a role, either because of external pressure or because of conflicts between approaches taken by units within the department. Not all of these examples illustrate totally new approaches to management. Interagency groups are clearly not new. But because they are employed in a department which is largely decentralized, they have tended to be taken more seriously than similar efforts in the past.

The seven case studies that have been included in this analysis highlight four types of crosscutting mechanisms: mechanisms for problem solving; mechanisms for coordination; mechanisms for information sharing/team building; and processes to balance a bottom-up and department-wide perspective. These cases include the role of the Office of the Secretary in improving human subjects protection; strategies for addressing racial and health disparities; the HHS Data Council; preparation for Y2K; Management Issues Lunches; the Budget Review Board; and the Government Performance and Results Act process.

They also illustrate the potential of the Office of the Secretary in a variety of roles. These examples indicate that it is possible to devise ways for the Office of the Secretary to become involved in the department's decision process without resorting to command-and-control approaches. The roles that are illustrated include seeking long-term solutions, broadening an issue, serving as a facilitator, encouraging bottom-up efforts, and translating technical issues to generalist language.

The challenge for the department is to provide a way to relate to each program unit individually and, at the same time, allow for the creation of an approach that makes sense for the department as a whole.

[2] *See Beryl A. Radin, "Managing Decentralized Departments: The Case of the U.S. Department of Health and Human Services," The PricewaterhouseCoopers Endowment for The Business of Government, October 1999.*

The Case Studies

Crosscutting Mechanisms for Problem Solving

Broadening an Issue and Playing a Neutral Party Role: The Role of the Office of the Secretary in Improving Human Subjects Protection

Early in 2000, attention was drawn to the role the federal government may have played in the death of a patient at the University of Pennsylvania as a result of an experimental gene transfer intervention during treatment. The main concern of the press was focused on the actions of the researchers at the University of Pennsylvania. But the fact that the research had been funded with federal dollars made it clear that it was important to examine the regulations that were in place to protect individuals who were subjects of clinical research.

This examination soon showed that the existing policies constituted a problem. Both the National Institutes of Health (NIH) and the Food and Drug Administration (FDA) had existing policies that were found to be inadequate, developed on the basis of different definitions and schedules, and that varied in terms of their enforcement efforts.

The HHS role in this area flowed from the growth in public funds appropriated to NIH for biomedical research after World War II as well as the statutory responsibility given to the FDA for regular clinical research associated with bringing drugs, vaccines and other biologics, and medical devices to market. Protection of human research subjects accompanied this effort, ensuring that human research

Case Study: Human Subjects Protection	
Organizations Involved	**Office of the Secretary:** Office of the Assistant Secretary for Planning and Evaluation Office of Public Health and Science **Agencies:** National Institutes of Health Food and Drug Administration
Problem/Issue	Responding to a public crisis and reviewing departmental human subject protection policies and procedure
Lead Organization	Office of Public Health and Science
Time Dimension	Short term/long term
Accomplishments	Broadened issues Clarified policies
Role of the Office of the Secretary	Planning role Limited operational role

subjects are protected from unreasonable risks, participate of their own free will, and make their decisions only after they have been informed fully about the potential risks and possible benefits of their participation. These efforts developed from the Nuremburg Code — the principles that were established following World War II in response to Nazi experimentation on human beings during that war.

The instrumentality for implementing the regulations that flowed from these principles is the Institutional Review Board (IRB). These bodies are established and operated by universities, hospitals, and other institutions that receive research awards from the federal government or other sponsors. They are responsible for reviewing proposed research protocols and informed consent statements before subjects are recruited and clinical research begins, as well as continuing oversight of the projects throughout their life cycle.

Although the public's concern about the effectiveness of these policies focused on the death at the University of Pennsylvania, there was already concern about the capability of the IRBs to carry out the responsibilities that were given to them. A series of three reports was issued in 1998 by the HHS Office of Inspector General (OIG), pointing to some of the problems associated with protection of human subjects and highlighting the demands and pressures on the IRBs that made it difficult for them to carry out their role. The OIG asserted that it was time for a fundamental reexamination and reengineering of the HHS oversight process in this area. In addition, in its report to the President, the National Bioethics Advisory Commission called for improvement in the accountability of IRBs and new techniques to ensure implementation of protections at the local level. Concern was voiced about the procedures used to manage financial conflicts of interest so that research subjects are neither misled nor coerced and that efforts would be made to assure that investigators and sponsors of research did not share financial interests in the research.

Two components within HHS shared responsibility for the IRBs: the NIH Office for Protection from Research Risks (OPRR) and the FDA. OPRR oversees IRBs operated by HHS awardee institutions (largely research and academic institutions) while FDA oversees IRBs that review clinical research related to products it regulates, irrespective of whether that research is ongoing at HHS awardee institutions or other sites.

Following the issuance of the OIG reports, both OPRR and the FDA stepped up the pace of their inspections of human subjects protection activities at research institutions within their areas. These activities reinforced the OIG conclusion that the IRB system is under considerable strain. However, while all of the HHS components agreed that persons who volunteer to be human subjects must be afforded the maximum protection from unnecessary risk, they did not agree on the specific steps that should be taken to deal with this problem. The two major units involved in this policy area differed in their approach to the issue and did not share a common strategy for dealing with the IRBs.

While there were significant actions taken in both the NIH and the FDA, until the death at the University of Pennsylvania there was no defined role for an overall department perspective that would be taken by the Office of the Secretary. The public concern about the specific research — gene therapy research — provoked a concern from the department's Deputy Secretary that resulted in involvement of the Deputy Assistant Secretary for Science Policy in the Office of the Assistant Secretary for Planning and Evaluation. That involvement meant that a department-wide perspective was developed that both broadened the scope of the immediate crisis issue and also created a permanent venue that was able to deal with cross-cutting issues.

A number of actions were taken at this point. A working group was established that focused on specific problems that were related to gene therapy. Plans for a series of conferences on safety were actually already in place, but both the NIH and the FDA needed to raise issues that crossed their organizational lines. The scrutiny of the activities disclosed that there were shortcomings in the monitoring of studies. While FDA subscribed to an international protocol on monitoring, the guidelines that were established did not require drug companies to monitor their gene therapy research. Shortcomings were also found in NIH's monitoring of studies.

The department perspective also emphasized the need to move out of the specific arena of gene therapy research. While those problems were severe, they were not unique. The structural problems in IRBs were a significant part of the gene therapy situation. As past reports had indicated, the IRB system was strained, operating without adequate resources or without appropriate stature on campuses. The analyses pointed to the possibility of focusing on the revenue stream that is available to reimburse awardees' expenditures for the indirect costs of research. This stream — often called "overhead" — was viewed as a potential source of funds for improvement in human subjects protection. The department strongly urged research institutions to strengthen their local efforts to protect human research subjects, to give their IRBs the standing and resources needed to do their job properly. This approach highlighted the reality that human subjects protection is a shared responsibility among the federal government, research institutions, IRBs, investigators, and sponsors.

As the issue moved beyond the program units to the Office of the Secretary, the approach emphasized strategies that were largely in agreement with the reports of the OIG. These included recasting federal requirements (highlighting a "just-in-time" approach for awardee institutions and reengineering the federal oversight process); strengthening continuing protections (emphasizing the role of the Data and Safety Monitoring Boards); and enacting educational requirements (making informative materials more readily available to the research community). The new approach also highlighted the need to help insulate both researchers and IRB members from financial conflicts of interest that threaten their independence.

HHS also determined that the human subjects component of the NIH OPRR should be elevated to the Office of Public Health and Science (OPHS) within the Office of the Secretary. Even before the death at the University of Pennsylvania, a decision was made to take this action. A new office was created — the Office for Human Research Protection (OHRP) — on the basis of advice from the National Bioethics Advisory Commission as well as the Advisory Committee to the Director of NIH. The director of the office was selected on the basis of a national search and a public advisory committee was created to help guide the OHRP and the department overall.

To some extent, the creation of this office recreated a more centralized approach to health policy issues. Yet the change continued to emphasize the important role of the program units. Until 1995, all of the public health units in the department were placed under the umbrella of an Assistant Secretary for Health. Theoretically, at least, both NIH and FDA reported through that Assistant Secretary (although they did operate as very separate and discrete units even when they reported to that Assistant Secretary).

The role played by the Office of the Secretary in this policy area has two aspects. The first was largely a planning function played by the Deputy Assistant Secretary for Science Policy. Once that planning opportunity was completed, the issue was handed to the program agencies as well as the new office. Both of these players — the program units and the OHRP — played an operational role, with the program units working closely with the Office of the Secretary to develop a shared strategy.

There are a number of challenges that are illustrated by this case:

- Many policy areas reflect different constituencies and definitions of work by the program units.
- Crisis problems are often a result of systemic issues and cannot be dealt with as unique phenomena.
- It is important to keep operational responsibility in program units even when the Office of the Secretary is involved.

Responding to a White House Initiative and Crafting a Department Response: Strategies for Addressing Health Disparities

In June 1997, President Clinton announced an initiative on race. That initiative was described as a critical element in the President's effort to prepare the U.S. to live as one country in the 21st century. Each cabinet department was asked to respond to this challenge. The HHS focus highlighted problems related to disparities in health outcomes. Although life expectancy and overall health has improved in recent years for a large number of

Americans, not all Americans were included. Because appropriate health care is often associated with an individual's economic status, race, and gender, a number of gaps were found in the health conditions of many racial and ethnic minorities. The effort sought to emphasize the underlying causes of higher levels of diseases, including poverty, lack of access to quality health services, environmental hazards in homes and neighborhoods, and the need for effective prevention programs tailored to specific community needs.

In addition to the White House interest in the issue, both the Secretary of HHS as well as the Surgeon General had already been concerned about the problem. It also resonated with various elements within the society, particularly with community groups and with the Black and Hispanic congressional caucuses. But while there was a convergence of interests on the topic, there was no agency or individual within the department that had played a department-wide public leadership role on the topic. While the Surgeon General could use his bully pulpit role to stimulate attention to the problem, the real ability to respond to the issue was found in the decentralized program units within the department and with various health groups within the society that had essential roles in the health delivery system.

Prior to the HHS reorganization in 1995, there might have been a response to this challenge through the Office of the Assistant Secretary for Health (a unit which contained all of the public health agencies). In reality, however, that office would have been confronted with the same problems that faced the department in 1997 — program autonomy and competing agendas. Some way had to be established to highlight the overall department concern about the issue and to develop a strategy that acknowledged the importance of actors both inside and outside of HHS.

The strategy that was devised included both a department-level response as well as a response from the individual program units. The locus for the efforts is found in the Office of the Assistant Secretary of Public Health and Science, through the efforts of a deputy assistant secretary whose responsibilities highlight these issues. Each agency within the department was asked to identify priorities within their program portfolio to address six areas in which there are health disparities among racial and ethnic minority populations: infant mortality, diabetes, cardiovascular disease, cancer screening and management, HIV/AIDS infection rates, and adult and childhood immunization.

Case Study: Strategies for Addressing Health Disparities

Organizations Involved	**Office of the Secretary:** Office of the Assistant Secretary for Planning and Evaluation Office of Public Health and Science **Agencies:** All
Problem/Issue	Responding to a White House directive that highlighted disparities in health outcomes often associated with race
Lead Organization	Office of Public Health and Science
Time Dimension	Short term/long term
Accomplishments	Developed department-wide focus; reviewed program portfolios
Role of the Office of the Secretary	Kept agenda before participants

Within the Office of the Secretary, the Assistant Secretary for Health/Surgeon General and the Assistant Secretary for Planning and Evaluation serve as co-directors of an effort that reviews the status of the department's goals to eliminate health disparities; consults with minority communities and the scientific and research communities; and reviews and recommends efforts related to the department's resources and programs.

Two committees were established that represented a cross-section of agencies to look at health and customer service concerns that impact minority populations. The departmental Minority Initiatives Steering Committee was designed to provide policy direction and guidance for key minority health initiatives (these include the Asian American and Pacific Islander Action Agenda, the Hispanic Agenda for Action, the Historically Black Colleges and Universities Initiative, and the Tribal Colleges and Universities Initiatives). This steering committee was chaired by the HHS Deputy Secretary and includes the Assistant Secretary for Health/Surgeon General, the Assistant Secretary for Management and Budget, and the heads or deputies of HHS program divisions.

In addition, a departmental Minority Initiatives Coordinating Committee was established, comprised of senior agency staff who report directly to agency heads or their deputies. The group works within the context of the steering committee policy directives and draws together the actual work of all four minority initiatives to avoid duplication and foster interagency cooperation on strategies to improve the health status of minorities. The department's approach was a three-pronged effort:

- Dialogue (broadening and strengthening its partnerships with state and local government, national and regional minority health and other minority-focused organizations, and minority community-based organizations)
- Research (attention to improvements in monitoring and developing the local and national data necessary for determining priorities and designing programs and research on ways to improve interactions and interventions in minority communities)
- Action (a number of new projects were designed to test different models for reducing disparities in specific minority communities).

Program units within the department have responded to the effort with a range of programs and new policies. Community coalitions were established in 18 states, funded by the Centers for Disease Control and Prevention, to help address racial and ethnic disparities in the six target areas. More than 30 community coalitions received funding for planning and will compete for implementation funds in the future.

In February 2000, a new Coordinating Center for Research on Health Disparities was proposed at the National Institutes of Health. The center would be in the Office of the NIH Director's Office of Research on Minority Health. This center was designed to facilitate the development of an NIH-wide Strategic Plan for Research on Health Disparities that would bring together each institute, center, and programmatic unit of NIH in a collaboration to better understand the causes of health disparities. This had been a longtime recommendation by the Congressional Black Caucus. To some extent, this office represented a centralization of functions. But more importantly, it served to provide symbolic attention to this set of issues.

In addition, the department took other steps:

- Publicized the first state-by-state look at risks for chronic diseases and injury for the five major racial and ethnic groups
- Collaborated with Grantmakers in Health (a consortium of foundations concerned about health issues) on a national leadership conference to generate ideas and identify action steps for the racial and ethnic health disparities initiative
- Developed an information World Wide Web site for the initiative to be used by interested media and communities
- Organized internal work groups in each of the six areas that are looking at HHS's existing programs and making recommendations
- Solicited public input about the issues from a series of regional meetings regarding Healthy People 2010, a set of overarching disease prevention and health promotion goals being pursued by the department
- Reviewed departmental data collection systems and made recommendations on how to improve data collection for racial and ethnic minorities.

There are several challenges that are illustrated by this example:

- This is an issue that requires programmatic attention across the department and cannot be dealt with by a single body.
- Past reorganizations can leave a void in the way that program units relate to one another.
- A number of program areas did not see this issue as a part of their responsibility.
- This issue not only involved actors inside the department but required action by a number of groups outside of the department.

Crosscutting Mechanisms for Coordination

Responding to the White House and Creating a Crosscutting Venue: The HHS Data Council

In March 1995, HHS was asked by Vice President Gore to develop a departmental response to issues related to promotion of health care applications of the national information infrastructure. The Vice President highlighted four different areas: data standards, privacy, enhanced health information for consumers, and telemedicine. Although the department already had work underway in each of these areas, the request asked for consolidation of ongoing efforts into a coherent strategy coordinated with other agencies, with attention to private sector and state roles in achieving more effective use of an information infrastructure for health care applications.

The White House request spawned a department-wide information policy initiative, handed to a department-wide committee to develop. That group not only focused on the four areas specified by the Vice President but also broadened the scope to focus on the department's own information system policies, moving away from categorical program-specific activities to a more integrated and cohesive approach to these issues.

By December 1995, the Secretary created a permanent, formal body that was constituted to reflect the reorganized HHS structure. That group would address the full range of health and nonhealth data and privacy questions identified by the working group.

Case Study: HHS Data Council

Organizations Involved	**Office of the Secretary:** Office of the Assistant Secretary for Planning and Evaluation Also others **Agencies:** All
Problem/Issue	Responding to the variety of data systems and policies and facilitating coordination across them
Lead Organization	Office of the Assistant Secretary for Planning and Evaluation Program
Time Dimension	Long term
Accomplishments	Creating venue to deal with issues
Role of the Office of the Secretary	Broadening to include generalist concerns

The Data Council's charge was to coordinate all HHS health and nonhealth data collection and analysis activities through a data collection strategy, coordination of activities, data standards and policy, and privacy policy activities. Membership on the council consists of all assistant secretary and agency administrator level HHS officials who have a direct reporting relationship to the Secretary, the HHS Privacy Advocate, and the Secretary's Senior Advisor on Health Statistics. It is co-chaired by the Assistant Secretary for Planning and Evaluation (located in the Office of the Secretary) and a rotating program head. Each member was asked to appoint an alternate to attend when the top official is not available and a staff contact person to handle communications about Data Council business. Staff for the council is provided by the Office of the Assistant Secretary for Planning and Evaluation.

The Council developed a six-item agenda that would guide its work:

- Develop a department-wide data collection strategy, including coordination and integration of surveys and oversight of surveys and general statistical analysis
- Coordinate HHS and inter-departmental health data standards activities, including the implementation of the Health Insurance Portability and Accountability Act
- Serve as HHS liaison for the National Committee on Vital and Health Statistics
- Serve as a focus for HHS issues relating to privacy of health and social services information
- Provide a forum for coordination of health and human services issues raised by the expanding national information infrastructure activities
- Provide a forum for coordination of HHS responses to external requests for HHS action on issues related to health and social services data.

As the Data Council evolved, its mandate became more complex. The passage of the Health Insurance Portability and Accountability Act of 1996 called for the department to develop standards that not only met the new expectations about electronic transmission but also made privacy protections. This latter responsibility required the Data Council to work closely with the National Committee on Vital and Health Statistics, the department's public advisory committee on health data, standards, privacy, and health information policy. In addition, the Data Council was also asked to respond to the need for data to be presented in a form that would provide information on race and ethnicity.

To accomplish these tasks, the Data Council organized itself into a number of working groups. These included the Survey Integration Work Group, the Joint Working Group on Telemedicine, the HHS Privacy Committee, the HHS Committee on Health Data Standards, the Working Group on Racial and Ethnic Data, and the Working Group on International Health Data Collaboration.

To a large extent, the meetings of the Data Council and the working groups were dominated by individuals who focused on the technical aspects of data collection, largely in health. The meetings did provide a forum for individuals with data responsibilities across the department to share concerns and provided a forum for the exchange of ideas. The agenda that was before the group reinforced this technical tendency.

While the forum did meet these needs, it also had a down side. Because the health focus of the group so dominated the agenda, there was minimal participation in the deliberations from the human services element in the department. For example, rarely did data issues confronting the Administration on Children and Families come before the data venue.

The Data Council members also found it difficult to translate their concerns to the budget process. Some participants in the process observed that a data strategy approach had not emerged from the council deliberations. A "wish list," rather than a set of priorities and issues that could be viewed in operational terms, was developed. As a result, data staff found that the budgets that emerged did not provide them with resources for data collection or with policies that allowed them to move to the next levels of electronic technology. The technical staff who dominated the Data Council were not able to translate their concerns in a way that prompted interest by the budget planners at either the individual program unit level or at the departmental level.

By 2000, steps were taken to address these problems. Individuals from the human services side of the department became more involved in the meetings, and Data Council meetings were used to help data staff understand the intricacies of the budget process. Some of this occurred as a result of increased involvement of individuals from the Office of the Secretary. While the operational aspects of data issues would continue to be the responsibility of the program units, the presence of staff from the Office of the Secretary helped to broaden the issues and move the activities of the Data Council from a highly specialized focus toward a more generalist orientation.

There are a number of challenges that are illustrated by this example:

- It is difficult for technical staff to find a way to relate to generalist processes such as the budget process.

- An organization this large and complex has a diversity of data systems that make it difficult to operate in a unitary fashion.
- The complexity of the assignment given to the group was extremely difficult and actually increased over time.
- There is a variability of interest in these issues by various program units.

Avoiding a Crisis and Establishing Department-wide Norms: Preparation for Y2K

There are few management issues that commanded the attention that was given to the federal government's efforts to avoid any computer crisis when January 1, 2000 arrived. Although there were some efforts within HHS to plan for the technical conversions that were necessary to prepare for the transition, the attention to the issue was located at a fairly low level in the department. It was not until the White House focused on this challenge that the HHS Deputy Secretary became involved. At the same time, members of Congress held a series of hearings on Y2K issues, focusing public attention on problems that might emerge if the federal agencies were not ready for the conversion.

The President's Management Council (PMC) began a government-wide effort that was orchestrated out of the White House and the Office of Management and Budget (OMB); a President's Council on Year 2000 Conversion was established and subgroups were formed to focus on the issues and problems that would be confronted by federal agencies. The HHS Deputy Secretary chaired the group that focused on transition issues in the health care system.

The initial effort to prepare for the Year 2000 was originally viewed as a computer problem. As time went by, it was soon realized that the problem was much broader because of so many system interdependencies and computer functions in devices other than computers (such as medical devices and card key entry systems). By the beginning of 1999, being ready for Y2K was the highest priority in the department.

The Deputy Secretary's involvement focused on the dimensions of the issue as a problem that cut across the department. He was particularly concerned about keeping continuity of health care intact when the due date came. This would not only involve the department's own computers but also systems that were found in hospitals and other aspects of the health care system.

Case Study: Y2K	
Organizations Involved	**Office of the Secretary:** Deputy Secretary Assistant Secretary for Management and Budget **Agencies:** All
Problem/Issue	Responding to public and congressional pressure and the need to coordinate departmental responses to Y2K
Lead Organization	Deputy Secretary
Time Dimension	Short term/long term
Accomplishments	Established department-wide norms to avert crisis Identified longer-term issues
Role of the Office of the Secretary	Conscience, reminder of problems Convened meetings Facilitated resources

Efforts were developed at three levels. The first involved the department's own systems (payments and other mission-critical priorities). The second highlighted the work of the partners involved in carrying out the work of the department (state agencies and other partners). And the third level involved the program sectors themselves, assuring that the missions of the department's programs could be accomplished (e.g., assuring an adequate supply of pharmaceuticals).

Working closely with the Office of the Assistant Secretary for Management and Budget, in 1998 the Deputy Secretary convened biweekly meetings with representatives of the program units. In most instances, the Chief Information Officer of a program unit attended the meetings and, in a number of cases, the program head attended. During these meetings, each element in the department was required to report on what it was doing to prepare for January 1. Following each meeting, a graph was prepared that presented the percentage of compliant Y2K mission-critical systems by program unit. The team's task was to collect and provide information on mission-critical systems, facilities, telecommunications, business continuity and contingency plans, and outreach efforts.

In addition, meetings were held with outside groups that were partners in carrying out HHS program responsibilities. Devolution of responsibilities to state and local governments as well as private and nonprofit groups meant that HHS would not be able to carry out its program mandates unless these groups were ready for the conversion. These included businesses, public service agencies, trade associations, and consumer groups.

The specific tasks required for each program unit varied, depending on the technical systems in place, the structure of the program (if it depended on others to carry out operations), and the level of resources required to make the change. The most complex tasks involved conversion of millions of computer codes within the Health Care Financing Administration, work with field offices and tribal contacts by the Indian Health Service, and systems in place at FDA and the Administration for Children and Families. In addition, the Program Support Center (the unit charged with implementation of payroll and other financial systems) was in the middle of changing to new computer systems. Given these challenges, efforts were made to focus on agencies with problems.

Although the precise requirements were diverse, the participants in the process recognized that the department would sink or swim as a single unit. During the initial meetings of the department's Y2K team, individuals appeared reluctant to share information, fearing the legal and proprietary problems that might emerge. A number of the program units found the biweekly meetings difficult and were frustrated by the complexity of the task and the time requirement to address the problems. Yet these program staff knew that the issue was of importance to the Secretary and the Deputy Secretary and that involvement of management from the top of the department was essential. As the sessions continued, the participants began to see that they could learn lessons from each other by discussing their experiences.

Before it left the department to become an independent agency, the Social Security Administration had begun its compliance activity. While it was in advance of some of the other department units, it was making these changes on its own, and there was not an opportunity for others to learn from SSA. No other part of the department had picked up on the SSA experience.

Involvement of top management also facilitated the ability of the program units to make successful requests for additional resources required to deal with the conversion. The President's Council on Year 2000 Conversion was able to put pressure on OMB to assure access to funds outside the regular budget process, and some of the program units received emergency support for conversion activities. The Assistant Secretary for Management and Budget (ASMB) acted as the conduit for these funds. By October 1999, all of the program units had 100 percent compliance in their Y2K mission-critical systems.

As January 1 neared, each of the program units and the Office of the Secretary established Day One Centers to monitor the status of the department's systems as well as those in the health care sector and in the states supporting HHS programs. These centers provided around the clock secure operations capable of receiving reports from the program units, public health organizations, other federal agencies, the pharmaceutical industry, and health care organizations. If required, the centers were able to analyze the reports quickly and provide accurate and timely information to the White House regarding the status of health care and human service sectors. The department also participated in the publication of a booklet for consumers that addressed specific patient and consumer concerns about the delivery of health care after January 1, offered suggestions for what

individuals could do to prepare for the transition, and provided the consumer with a list of resources for additional information. In addition, technical assistance was provided to state partners, especially by ASMB staff.

As it assessed its preparatory activities for the Year 2000 conversion, HHS reported that it remediated 284 mission-critical systems, 890 non-mission-critical systems, 146,051 data exchanges, 6,225 telecommunication devices, 3,727 HHS-owned or -managed facilities, and 26,217 HHS-owned medical devices. HHS also hosted six international U.S. Information Agency-sponsored Y2K groups to promote an international exchange of information and provide U.S. expertise. The preparation resulted in a largely problem-free experience. In effect, there were no problems for any of the HHS systems nor in the nation's health care or human service system.

Although the department-wide activities were focused on Y2K compliance, the actions that were taken to prepare for the transition created a better understanding of how the department's diverse computer systems work and about the people who operate them. The Y2K effort required each organization in the department to inventory and audit its existing installed base of hardware and software. Systems were identified as mission-critical, high impact, obsolete, or in need of upgrades and redesign. In addition, the lessons learned through the year 2000 efforts contributed to an understanding of policy, procedure, and security issues that will be addressed by the components in the department in upcoming years.

Several challenges are illustrated by this example:

- Political and public attention to the issue can put severe pressure on agency decision-makers to respond.
- It is difficult to move issues from technical dimensions to the broader policy system.
- There is often variability in the capacity of program units to respond to an issue and, as well, variability in the intensity of the problem across the department.
- Concern about the demands and an initial lack of trust involves the direct involvement of the Deputy Secretary.
- A crisis environment can be used to broaden the issue and focus on long-term responses.

Crosscutting Mechanisms for Information Sharing/Team Building

Creating an Informal Management Forum: The Management Issues Luncheon Meetings

During the first years of the Clinton administration, the HHS Deputy Secretary scheduled regular meetings that involved all of the individuals within the Office of the Secretary who had some form of management responsibility. Following the reorganization of the department in 1995, a decision was made to broaden those meetings to include individuals from the program units with major management duties.

Beginning in mid-1996, meetings were held to provide a venue for individuals concerned with management of the large, complex department to discuss issues and exchange ideas in an informal setting. The Assistant Secretary for Management and Budget serves as the convener and chair of the sessions. In addition, the meetings are viewed as opportunities to prepare for and follow up on meetings of the President's Management Council, the Chief Financial Officers Council, and other government-wide management groups.

Despite the prominent role of the ASMB, the group has evolved into a highly interactive body with program unit participants taking responsibility for the activities. The meetings (usually held on a monthly basis) follow a common format. Opportunities are given to participants to make announcements and provide updates on current developments; a few topical issues are discussed, usually on the basis of presentations from the appropriate department staffer; and time is provided for members to raise issues that were on their minds. Minutes are not taken of the discussions and, since decisions are not actually made in this setting, there is no formal codification of the discussion (even when there is an agreement among the participants).

The individuals who are invited to participate in the sessions are the top management officers in each organization — usually a deputy in that unit or the individual who serves as the executive officer. Most of the parties involved in the meetings are career staffers, with a few political appointees where relevant. Attendance at the luncheons is very good; rarely do those who are invited send a subordinate staff member.

Case Study: Management Issues Lunches	
Organizations Involved	**Office of the Secretary:** Assistant Secretary for Management and Budget **Agencies:** All
Problem/Issue	Responding to the need for senior leaders in the department to discuss major management issues
Lead Organization	Assistant Secretary for Management and Budget
Time Dimension	Long term
Accomplishments	Established safe haven for participation and discussion
Role of the Office of the Secretary	Facilitated exchange of views Provided information on current developments

During the first several years of the luncheon meetings, the agendas included updates on the budget, discussion of labor management partnerships, the quality of work life strategy, pass-fail performance management systems, human resource planning studies, and updates on the strategic plan and performance plans required by the Government Performance and Results Act (GPRA). In addition, individuals were invited from other agencies to give presentations on the National Performance Review and flexiplace and telecommuting policies.

By the end of 1997, planning groups were organized, composed of participants in the sessions. These groups included teams focusing on human resources/organization development; GPRA/strategic planning; systems/information technology; and financial management. Each of the groups was asked to elect a chair and develop a list of possible issues or actions that would serve as an action agenda for the Management Issues Luncheon meetings. These groups presented their proposed action agenda at the January 1998 meeting, highlighting specific ways to address the issues or actions identified and a tentative timetable for dealing with them. Each planning group took responsibility for each monthly meeting during 1998. In addition to the planning group reports, discussions were also held on credit card expansion; travel policies; early out and/or buyout authority; electronic commerce; audits; department-wide employee surveys; and developments in the Public Health Service Commissioned Corps.

At the end of 1998, participants were asked to evaluate the meetings in more than an anecdotal fashion. The responses indicated that these meetings were addressing the needs of the participants as management officials. The evaluation included the following comments about the Management Issues Luncheon meetings:

- "They brought to focus issues that are relevant and of concern throughout the department."
- "They provided an opportunity to meet and network with counterparts in other operating and staff components."
- "They had a specific topic to focus on, as well as an opportunity for discussion on subjects of current interest. All subjects had relevance to issues on which I normally work."
- "The luncheons provide an opportunity for management officials in the various operating divisions to get to know each other, which makes doing business with them outside the meetings much easier."
- "They allowed operating division managers to see how other operating divisions are addressing issues that we all have to address and provide information on relevant topics."

Participants were also asked for recommendations for future meetings:

- "Allow at least 15 minutes of "peer time" at each meeting for discussion of whatever is on people's minds."
- "Ask the Assistant Secretary for Management and Budget to report each month on the previous month's important activities of the Secretary and Deputy Secretary."

- "Continue topic focus but leave time for budget status, Hill updates, GPRA status, etc. Invite knowledge outsiders (or insiders) to make brief presentations on these subjects."
- "We don't always take full advantage of opportunities to discuss some of the issues more broadly. Some topics clearly deserve more attention than we have been giving them."

During 2000, responding to these suggestions, sessions focused on Census 2000, the HHS Distributed Learning Network, and problems involving fiscal management practices at the Centers for Disease Control (CDC). In all of these meetings, the participants found it useful to talk about management issues as ideas, treating them on a conceptual level.

Several challenges are illustrated by this example:

- The tradition of dealing with the Office of the Secretary management office in a top-down fashion is difficult to break.
- The top management officials in the program units have few opportunities to discuss issues in a "safe" environment.
- A non-decision venue provides a way to allow program officials to understand the department-wide perspective, moving beyond "stovepipes."

Crosscutting Processes to Balance Bottom-Up and Department-wide Perspectives

Replacing Centralized Budgeting with a Collegial Process: Recasting the Budget Review Board

For many years, predating the Clinton administration, the budget process within the Office of the Secretary had been the vehicle for exerting a strong, centralized Office of the Secretary perspective. Both program and staff units within the department presented their budget requests in the early summer of each year to a board composed of top officials from the Office of the Secretary. Members of the Budget Review Board (BRB) have traditionally included the Assistant Secretary for Management and Budget (serving as the chair), the Assistant Secretary for Planning and Evaluation, the Assistant Secretary for Legislation, and the Assistant Secretary for Health.

Prior to the 1995 reorganization, the Assistant Secretary for Health developed a budget that included all of the public health components (including the NIH, FDA, and CDC). After that reorganization each of those components presented its own budget individually to the BRB, joining the non-health units within HHS. The head of each of the program units within the department explained the policy issues facing that agency and how the budget requested would improve the health and well-being of the nation. In the past, the agency heads often came to the BRB as supplicants, requesting expenditure authority that may or may not have been approved by the BRB and the Secretary. This was the first stage of a very complex process, moving from the BRB to the Secretary and then to OMB. The "pass-back" from OMB could then be appealed by the Secretary, first to the OMB Director and then to the President. That was the budget that eventually was presented to the Congress. If a program unit did not receive its request, it was common that the agency (or its constituency) developed an end-run strategy, working around the Secretary and advocating increases in the budget in other decision venues.

The process that was put in place by Secretary Shalala was built around her acknowledgment that the department is a highly decentralized and diverse organization. She is comfortable serving as an advocate for the program units, supports their agendas, and relies on personal relationships and policy discussion to transmit her own perspective. Thus the BRB's approach has changed over the past eight years, moving away from a centralized control strategy to one in which the Office of the Secretary acknowledges the need for autonomy and discretion within the program units.[3]

At the same time, however, the BRB meetings are organized to help program units construct their budgets in an effective manner, emphasizing themes or specific initiatives highlighted by the Secretary. The staff work for the meetings is done by the Budget Office within the Office of the Assistant Secretary for Management and Budget. The staff in that office is organized to parallel the structure of the department. While ASMB has tried not to be overly directive in its guidance and to give program budget managers

[3] *See Radin, 1999, pp. 16-17 for a partial discussion of these issues.*

Case Study: Budget Review Board	
Organizations Involved	**Office of the Secretary:** Assistant Secretary for Management and Budget Office of the Assistant Secretary for Planning and Evaluation Office of Public Health and Science **Agencies:** All
Problem/Issue	Modifying centralized budgeting to be more collegial
Lead Organization	Assistant Secretary for Management and Budget
Time Dimension	Once a year
Accomplishments	Created collegial process Established forum for balancing competing values
Role of the Office of the Secretary	Defined parameters and framework for discussion

some freedom in how they develop their justifications, it has found that this may result in inconsistencies in the presentation of information.

The BRB helps define the issues in the budget and through discussion assists the program units in determining what aspects of the request should be emphasized as the budget is presented to the Secretary. The heads of the operating programs are queried about their requests and asked to indicate how those requests mesh with the Secretary's initiatives. Representatives of program units other than the one presenting its budget are encouraged to sit in on these presentations. When specific elements are to be included in the budget documents — such as the annual performance plans required by the Government Performance and Results Act — those elements are also discussed in the presentations. In calendar year 2000, the members of the BRB spent more than 60 hours reviewing the agency budget requests. The discussions that take place during the BRB sessions do not result in a collective recommendation; rather, they involve an exchange of information between participants.

Later in the summer, the budgets are presented to the Secretary and the Deputy Secretary in a setting which includes all of the senior staff within the department. All of the agencies have an opportunity to review each other's budgets and to comment on areas that are of shared interest. The program unit heads are expected to sit in on each other's presentation to understand the activities of the department as a whole. When these presentations are concluded, all of these individuals are asked to prepare a budget for the entire department by voting on allocations — an exercise that emphasizes the importance of looking at the submission from the perspective of the Secretary. This process gives them some sense of competing values that characterize the programs in the department and allows them to develop a sensitivity to the overwhelming demands on the budget that will finally emerge from the department. The Secretary imposes a constraint of an overall budget amount and senior staff make their recommendations within this constraint. Not everything that is requested by the program units appears in the final budget.

The Secretary has four primary sources of inputs to inform her budget decisions: the briefing materials provided by ASMB staff, the program presentations at the Secretary's meetings, the results of the ballot vote, and ASMB recommendations on aggregate budget levels. The final budget represents a melding of the Secretary's priorities and program requests from the agencies. This approach minimizes the conflict among programs for resources when they operate with limited resources. While cuts are frequently recommended by OMB, in a number of instances the Secretary has been successful in appealing them to the OMB Director or to the President. The unified position within the department has contributed to this success. As such, budget conflict rarely occurs within the department and a unified position is submitted to OMB. The transparency of the process minimizes

the practice of program agencies end-running to OMB. At least in some cases, instead of battling inside the department, the battle is moved to the Executive Office of the President.

This example illustrates several challenges:

- It is not easy to move away from the tradition of central budgeting.
- It is difficult to get beyond the narrow interests of program units.
- It is possible to define a department-wide budget.
- It is possible to make cuts in program unit requests that are understood by top program staff and more or less committed to by them.

Moving to Shared Perspectives and a Common Language: Developing the Performance Plans Required by the Government Performance and Results Act

After the passage of the Government Performance and Results Act 1993, the HHS response to the requirements of the legislation was found within the separate program units within the department. This strategy acknowledged the size and decentralized nature of the department. While charged with the implementation of approximately 300 programs, the size and disparate functions of these programs lent themselves to a decentralized approach to program management and performance measurement.

Although the specific requirements of the legislation did not go into effect until 1997, several of the HHS program agencies decided to devise pilot projects (a possibility included in the law) that might serve as demonstrations or examples for others. However, there was limited attention to these pilot efforts within other parts of the department since the two major requirements of the legislation — a five-year strategic plan and annual performance plans — were not immediate demands.

In 1996, work began seriously on the HHS strategic plan, led by the Office of the Assistant Secretary for Planning and Evaluation (ASPE). Although a staff level work group had been formed in early 1994 to develop a department-wide plan and provide technical assistance to the program units as they developed their own plans, these efforts were disrupted by the health care reform initiative and reinvention activities. The guidelines that had been established for that staff-level work group called for a two-part plan — a department-wide part with broad, crosscutting goals and objectives and agency-specific plans to supplement the crosscutting goals.

Case Study: Government Performance and Results Act

Organizations Involved	**Office of the Secretary:** Assistant Secretary for Management and Budget **Agencies:** All
Problem/Issue	Responding to requirements of Government Performance and Results Act
Lead Organization	Assistant Secretary for Management and Budget
Time Dimension	Long term
Accomplishments	Developed common language, shared perspective
Role of the Office of the Secretary	Developed analytic reports that highlight shared programs and crosscutting goals Played facilitating role

In the fall of 1996, concerns were expressed about the strategic plan that was emerging through this process. Its critics argued that the plan lacked vision and a strategic focus. The two-level approach was thought to create multiple layers and a large number of goals, objectives, and strategies that were uncoordinated, duplicative, and did not flow from one another. It was described as the product of a staff-level process, resulting in goals, objectives, and strategies that satisfy major program and constituent

interests but fail to articulate a vision or priorities. As a result of these criticisms, the Secretary and Deputy Secretary decided that a document would be written by a few top staffers in ASPE and circulated within the department before it became final. Thus a bottom-up approach was replaced by a document developed in a top-down fashion.

While this document did present a picture of a unified department, held together by six overarching goals, the strategic plan did not easily fit into the fragmented decision-making structure that is a part of the HHS reality. Both appropriation and authorizing committees in the Congress focus on specific program areas, not on broad goals. Even the staff of OMB scrutinizes only specific elements of the department's programs since a number of separate budget examiners have responsibility for specific program areas. And the approach did not seem consistent with the management approach taken by the Secretary and Deputy Secretary.

In part in reaction to the more centralized ASPE process, the Office of the Assistant Secretary for Management and Budget — the unit within the Office of the Secretary that was given responsibility for the development of the annual performance plans required by GPRA — developed a strategy that emphasized the unique nature of the individual HHS program components. Because the performance plans were attached to the budget submissions, their development was clearly a bottom-up process.

During the first several years of the process, the role of ASMB was that of a gentle facilitator, attempting to provide opportunities for representatives of program units to raise questions and discuss their experiences. The annual performance plans that were devised were very different from one another. While most of the program units made some reference to the themes established by the strategic plan, their performance plans — as their budgets — emphasized quite diverse goals and objectives.

While the deliberations within the congressional appropriations process did not indicate that members of Congress were focused on the problems that stemmed from the diversity of these documents, there was strong criticism of the HHS submissions by the General Accounting Office and by the Republican leadership in the Congress. The model of decision-making that was employed by these critics assumed that HHS was managed as a centralized, command-and-control department. While this model was not realistic for a department the size and scope of HHS (nor did it comport with the Secretary's personal approach), there was a danger that the criticism of the GPRA submissions could cause problems for the department.

Thus the staff of ASMB was faced with a dilemma: how could it respect the diversity and autonomy of the program units and, at the same time, find ways to address the critics who sought a unified, single document? In addition, there clearly was a range of GPRA-related competencies within the department, and it would be useful for program unit staff to find ways to learn from one another.

The strategy that was employed within ASMB contained several aspects. The ASMB staff developed a performance plan summary document that did provide a more unified picture of the department. It focused on the linkage between program unit goals and objectives and departmental initiatives and the HHS strategic plan. It highlighted crosscutting areas, drawing on the individual performance plans to illustrate shared areas. It set out the HHS approach to performance measurement and the close relationship between the department's budget development process and the GPRA performance plans.

In addition, the ASMB staff held a series of conference calls that provided an opportunity for program unit staff to discuss issues, share experiences, and develop a collegial (almost collective) approach to the task. These calls (and some face-to-face meetings) were constructed to provide methods of active rather than passive involvement in the process.

Finally, the ASMB staff worked closely with a subgroup of the GPRA program unit staff to develop a standardized format which all program components agreed to use for their FY 2001 performance plans and their FY 1999 performance reports. This format established a consistent "order of presentation" of information required by the law and OMB for performance plans and reports. While the program units followed the standardized format to make certain that they met all of the requirements of the

law, significant flexibility remained to ensure that the units were able to tailor their performance plans and reports to meet their individual needs. Some components chose to present certain types of performance information at the agency level; others chose to present information at the program or goal level. For the reader who was required to assess all of the HHS performance plans, this shared format painted a picture of some level of consistency across the program units and did make the job of reading the documents somewhat easier.

There are several challenges that are illustrated by this example:

- Analytic efforts seem to provoke a tendency for the Office of the Secretary to fall back on past centralized practices.
- It is possible to move to a sense of the department as a whole through facilitating rather than controlling strategy.
- Public attention and legislative requirements can evoke a set of external pressures to develop a department-wide perspective.
- It is important to find ways to respect the individual cultures and approaches of program units.

Conclusions and Recommendations

The examples that have been presented indicate that a department as large and diverse as HHS has been able to craft a role for the Office of the Secretary without relying on traditional modes and approaches to make its views known. This experience should be useful to other cabinet Secretaries. While the experience of HHS does have some unique aspects, the lessons that can be drawn from these examples reach beyond this single federal department.

Indeed, the examples seem to fit with the fragmented nature of the external decision-making institutions in the U.S. government to which federal agencies are accountable, especially the structure and processes found within the Congress. Cabinet officials can expect to be required to respond to emergent problems and issues that are not a part of their own agendas. These items emerge from both internal and external demands.

While the Office of the Secretary may no longer emphasize a command-and-control role within a department, it does have other roles that are extremely useful to a cabinet Secretary. The units within the Office of the Secretary have the ability to move program units to seek longer-term solutions than those that may emerge from a crisis or immediate set of demands. They have the ability to broaden an issue beyond a narrow solution. The units in the Office of the Secretary can serve as a facilitator, encourage a bottom-up process within the department, and can help technical staff translate their concerns to be able to communicate to less specialized staff.

The units within the Office of the Secretary have the ability to help program unit staff move beyond their specialized and specific concerns and escape from what are called their "stovepipe" perspectives. In addition, these units can devise patterns of participation that draw on staff who move beyond narrow representational roles.

There are a number of characteristics of these examples that should be emphasized:

- Traditional management techniques take on a different meaning when they are used in a decentralized agency. This is especially illustrated by the activities undertaken by the Management Issues Lunches.
- The Office of the Secretary is able to respond to crises or perceived crises in ways that are effective. Both the human subjects example and the Y2K experience indicate that involvement of the Office of the Secretary allows the department to look beyond the crisis and to define approaches that provide longer-term change. The Deputy Secretary can play an important role in this regard.

- Office of the Secretary involvement provides a vehicle to broaden an issue and move it beyond a narrow constituency. This is particularly important in programs that involve partnerships with others (e.g., state and local governments, tribes, nonprofit organizations). This dynamic was found in the racial disparities example as well as the human subjects case.
- The Office of the Secretary can play an effective role as a facilitator. It can create venues that provide a setting for collegial exchange of views and a low-key way to develop collaborative strategies. This was found in the Management Issues Lunches, GPRA, and the Data Council. This is not a traditional role for the Office of the Secretary, but it can act to facilitate the active involvement of program units.
- The Office of the Secretary can be an effective participant in efforts that are clearly bottom-up. This is illustrated by the Budget Review Board activities as well as the GPRA effort. Designing settings that allow program officials to share information in a non-threatening role can avoid a narrow compliance attitude.
- The Office of the Secretary may be able to create modes of interaction between technical/specialist staff and generalist managers. This was found in the Data Council activity.
- Budget processes can serve as the centerpiece for many of these efforts. The budget process can be structured in a way that avoids turning program units into supplicants. The BRB example indicates how those units can be empowered during the budget process.

The crafting of a particular crosscutting approach depends on several variables, which can lead to a range of approaches. These include a broad problem-solving approach; an ad-hoc, time-limited effort; an approach that is specifically designed to avoid traditional hierarchical bureaucratic behavior; and an approach that is developed around existing decision processes. Thus a cabinet Secretary might examine:

- *The clarity of the external mandate that provokes the activity.* Specific directives from the White House or the Congress create a sense of immediacy, and these mandates are easily communicated to the participants in a time-limited fashion. While the Office of the Secretary may move the immediate demand to seek longer-term solutions or broaden the issues, it is required to first deal with the mandate.
- *The breadth of the required participants.* If an effort involves only a few program units, then it can be targeted at those units. If, however, it involves a wide range of program and staff offices, then it takes on a less direct strategy. In these cases, the Office of the Secretary may decide to play a facilitating role.
- *The time frame involved.* Some efforts stimulated by the Office of the Secretary involve short time frames. Often these efforts are quite ad hoc in nature and do not move into institutionalized processes. Others, however, may begin with short time demands but are turned into longer term agendas.

It is possible to devise ways for the Office of the Secretary to become involved in the department's decision process without resorting to command-and-control approaches. Care must be taken in the way that program units are treated; they must be respected, not tolerated. The examples of crosscutting and coordinating mechanisms that have been presented suggest that these new approaches to management within the Office of the Secretary must be applied with modest expectations. Not all areas are appropriate for an active Office of the Secretary role, and it is important to work hard to avoid preempting the program units. At the same time, these approaches do provide a way for a diverse agency to develop a corporate identity in which the whole is greater than the sum of the parts.

About the Author

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