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Walden University

College of Management and Human Potential

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Cassandra Ada Marie Austin Jones Speed

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2023

Abstract

Leadership Decisions Related to Hospital Mergers in New England

by

Cassandra Ada Marie Austin Jones Speed

MPHIL, Walden University, 2019

MBA, University of Phoenix, 2010

BS, University of Phoenix, 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Management

Walden University

November 2023

Abstract

The purpose of this qualitative narrative inquiry was to explore the experiences of healthcare leaders related to merger decisions and potential strategies for implementation of leadership in a merger context. Currently, there have not been any research studies investigating the lived experiences of leaders through the merger process. This gap in knowledge is vital to business operations, transformations, and transactions across the healthcare industry as mergers grow in number, size, and complexity. This research explored the lived experiences of healthcare leaders that greatly impact the healthcare industry and hospitals across the New England region. The conceptual framework guiding this study was observational experiential learning theory. The goal was to understand how the decision to merge was reached by conducting reflective interviews with leaders who have been involved in recent mergers within the New England area. There were 6 participants at the C-Suite executive level interviewed for this study. The transcribed interview data was analyzed line-by-line then coded for themes. The major themes produced by this research were: strategic planning, challenges, communication, merger guidance, and leadership. Leaders are the change agents that drive mergers and healthcare at many levels. Leaders address challenges, provide innovative strategies to improve healthcare, and find solutions. The positive social change that this research will avail us of is better preparation for the merger process, which may lead to better outcomes and more effective experiences for all involved. The knowledge shared could position leaders to bring about a stronger healthcare industry and population health.

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Dedication

I would like to dedicate this project to my children (Sean, Seanice, Sharane, and Antonio). They have supported me throughout the long days and nights, working on papers, reading articles, being preoccupied, and often missing in action. I truly thank each of them for taking care of each other because I had to work or had research to do or project deadlines to meet instead of spending quality time with them. I would also like to thank my mother (Willie Mae Austin) for providing spiritual support and praying for me when I thought I could not do any more papers. They are truly my inspiration as I wanted to be the first of my mother's children to obtain a Ph.D. and show them that anything is possible if you work hard and dedicate effort toward that goal. Last, I would like to thank both of my former husbands: Sean for being there to cook dinner when I was too tired and Delance for all the emotional support when I was falling apart. You are both the best friends a woman could ever ask for (past, present, and future). I love you all and thank you for being my village throughout my academic career.

Acknowledgments

I would like to thank my committee members: Dr. Richard Dool and Dr. Robert Haussmann. Without them and the Lord Jesus Christ, this would not be possible. It has been an exceedingly long and thankless road. I am here to say, “Thank you!” for putting up with all of the emails, text messages, questions, challenges, and rough times. I am incredibly grateful and honored to have worked with you both. Best regards to the future ahead.

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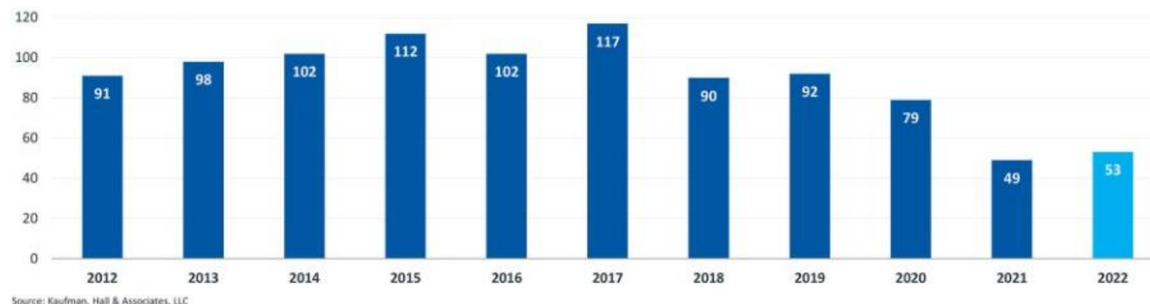
Chapter 1: Introduction to the Study

Mergers have become commonplace in operations in healthcare (Levin, 2016). A change occurred in 2018 with the creation of the mega-merger. A mega-merger is a large and complex merger (Reiss & Pryor, 2019). While further categorized as having a value of 20 billion dollars or more, 79 mergers in 2020, by this value, were large and complex, likely due to the COVID-19 pandemic, which brought new challenges (Barnes & Magnuson, 2021). In this study, I examined mergers of hospitals and other healthcare systems in New England. Importantly, the mega-merger brought together seven hospitals with over 23,500 employees (King, 2021). Another notable New England merger was that of a Massachusetts health system, UMass Memorial Health Care and Harrington Health Care, in September 2020 (UMass Memorial Health, 2020). The stated benefits of this mega-merger included investment in facilities and infrastructure to provide high-quality, affordable access to medical care (UMass Memorial Health, 2020).

There were also 90 mergers in 2019 of varying size and complexity (Reed, 2019). Healthcare mergers historically included 98 mergers in 2013, 95 mergers in 2014 (Curfman, 2015), 112 mergers in 2015, 102 mergers in 2016 and 115 mergers in 2017 (Kaufman, 2018; Minemyer, 2018), 90 mergers in 2018, 90 mergers in 2019, and 79 mergers in 2020 (Barstow, 2018; King, 2021; Levin, 2016; Minemyer, 2018). This data is summarized in Figure 1, which demonstrates the apparent trend of mergers increasing in recent years and then shifting in complexity.

Figure 1

Trend of United States-Based Mergers from 2012-2022



Note. *Reproduced from Singh (2022).*

Gaynor et al. (2013) stated that the number of hospital merger transactions since 2010 demonstrated a trend impacting the healthcare industry and the future of healthcare. This merger phenomenon has been called a *spree* (Barstow, 2018) and was not showing any signs of stopping but, instead, was getting larger (Reed, 2019). For this reason, it is imperative to understand how the decision to merge became the initiative chosen by healthcare leaders rather than other options. Today, coronavirus implications have impacted the merger phenomenon in unprecedented ways. The coronavirus pandemic became a catalyst for diversification to include greater complexity in recent mergers and the increase in dollar value of mergers (Harroch, 2020). The total value of mergers climbed from $202 billion in 2010 to $541 billion in 2019; ultimately, there were $339 billion in mergers in 2020 (Appendix A) (Harroch, 2020). Merger dynamics continue to change, as does the need for leadership knowledge and experience, prompting exploration into this process (Dalia, 2020; Reed, 2019).

Background of the Study

I selected articles relating to healthcare mergers from the Walden Library multi-databases (Thoreau), Google Scholar, and governmental agencies via the following process. The searches employed the following keywords and a combination of keywords: *healthcare, hospitals, mergers, leadership, decision-making, and lived experiences*. I identified several sources about mergers' impacts on the healthcare industry, postimplementation healthcare merger statistics, financial reasons, and healthcare merger outcomes. However, there was no detailed research concerning why healthcare administrators decided to merge, further highlighting a gap in the literature and underscoring the need for research on this topic. Specifically, it was critical to increase the body of knowledge regarding leadership experiences and decisions before implementing healthcare mergers.

Barilla et al. (2019) analyzed the need for bold leadership to transform healthcare in the United States and advocated for this research need. Chan (2018) shared concerns that such mergers and mega-mergers drive up the cost of healthcare, making care unaffordable to many patients. In contrast, Frakt (2019) provided research regarding evidence of hospital mergers leading to healthcare improvement. This disagreement between respected scholarly sources only underscores the need to explore further the decision to initiate and complete a healthcare merger. This decision requires all positive and negative ramifications to be considered.

Researchers have discussed understanding the shift to improve healthcare management in the community and how society can be better prepared to manage

healthcare strategies, delivery methods, and the inner workings of mergers in the future (Jarouse, 2015). Other researchers have shared examples of how large healthcare systems can drive prices to be higher and impact healthcare spending (Kacik, 2018a, 2018b). Yet, as stated above, there is disagreement regarding whether healthcare mergers drive prices up or down for consumers.

Other researchers have provided information on how hospital mergers and acquisitions change healthcare as the number of mergers continues to rise (Lapointe, 2018). The emergence of merger trends drove researchers to assess information regarding the new landscape in the healthcare industry (Martin, 2018). Moseley et al. (2019) provided the basis for the experiential learning theory conceptual framework, which I explored in this study. Noether and May (2017) authored a report on hospital merger benefits from the leadership perspective combined with economic analyses. Xu et al. (2015) researched the viewpoint of hazards with hospital consolidations on access, price, and quality. These studies highlighted the need to deeply understand mergers in the healthcare field, particularly from the leader's perspective, as it is ultimately the leader's experiences that drive the decision to merge. The region I researched was New England, where many pertinent and historical mergers have occurred. Table 1 provides regional data regarding the types of healthcare facilities across New England and why this was an excellent region to study. As shown in Table 1, New England has four trauma-level facilities across the region that demonstrate a robust medical industry and afford leadership that are shaping the infrastructure of many healthcare organizations.

Table 1

New England Hospitals

Hospital type	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
Level 1 trauma center	4	1	8	1	1	1
Level 2 trauma center	8	2	3	1	0	1
Level 3 trauma center	1	0	6	10	0	0
Level 4 trauma center	0	0	0	2	0	0
Unspecified hospitals	17	29	47	13	12	12
Total:	30	32	64	27	13	14

New England is in the northeastern part of the United States and contains six states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. These states have a combined 180 hospitals (Cirulli & Marini, 2022; Dyrda, 2017; Table 1). This region is well known for being the location of some of the most prestigious healthcare affiliates and academic organizations, such as Harvard University, Yale University, Massachusetts Institute of Technology, University of Connecticut, Dartmouth College, Brown University, Tufts University, and Bowdoin College. While all these universities do not have hospitals associated with them, many do. As such, New England has a wealth of knowledge to share with the world in education and healthcare.

New England has also been the site of many landmark mergers; for example, there have been more than 300 since 2013, ranging from healthcare system creations, hospital acquisitions, physician group acquisitions, provider mergers, and clinical affiliations to the formation of contracting entities or organization, mergers with insurance carriers, to acquisition by academic institutions (Massachusetts Health Policy Commission, 2022). A few mergers in New England have consolidated more than 10

hospitals at a time. These mergers have been substantial in size and complexity, sparking my interest and inquiry about the lived experiences of the leaders who decided to initiate mergers and consolidate with other entities.

Problem Statement

Frakt (2019) and King (2021) explained that mergers may not improve the quality of care, decrease patient costs, or improve population health. Still, mergers continue to be a chosen approach by many healthcare leaders, as evidenced by the number of mergers remaining largely steady or growing in recent years (King, 2021). Frakt (2019) provided arguments that showed healthcare merger outcomes have contradictions regarding patient access to quality care, decreased costs to patients and hospitals, positive impacts on population health, market-share competitiveness, and decreases in healthcare spending. These variables and impacts may vary from merger to merger, which even further highlights the need for research in this area.

In contrast, Noether and May (2017) researched the benefits of mergers from a leadership perspective, showing that understanding the lived experiences of healthcare leaders who make merger decisions may be a good indicator for exploring the merger phenomenon. It is not known what factors influence leadership decisions to merge multiple hospitals into a single organization (Martin, 2018). The specific problem that I addressed in this study was the inability to identify factors for leadership decisions that may induce better hospital mergers and the need for options for a more strategic approach. Exploring the experiences of New England healthcare industry leaders before the decision to merge could lend insight into the origination of the merger phenomenon.

According to Merriam and Tisdell (2015), the merger phenomenon significantly changed how the healthcare industry operated.

This research filled a literature gap from the leadership lens of healthcare mergers in New England. This study helped fill the gap by providing information and strategies to successfully navigate the merger process for ideal gains while leveraging cost synergies. Hassan et al. (2018) researched merger and acquisition motives and outcome assessments. The findings called for more research to help management better define merger motives and evaluate outcomes appropriately. I collected premerger information from leaders and added it to the body of knowledge, as Hassan et al. (2018) suggested. Also, Welch et al. (2020) conducted research and review of the predeal phase of mergers and acquisitions, and they recommend additional research be conducted on merger initiation and the studying of executive characteristics, which was my objective with this research. I provided information about potential frameworks for mergers so that they can achieve goals while leveraging analytics to enhance benefits in the medical arena. Geisler et al. (2010) addressed the existing and developing new concepts of leadership and management and evaluated whether mixed qualitative-quantitative methods can provide critical information for large healthcare mergers. The results showed that the split scenario divided organizations into independent hospitals and explained that knowledge-driven organizations might be tapped as a knowledge resource for successful future business models for complex mergers (Geisler et al., 2010). My study followed up on some of these gaps by providing real-world methods for strategic planning in large health care merger organizations.

There have been many research studies about mergers, such as a versatile article encompassing multiple mergers with varying outcomes by Frakt (2019). This volatility affords the need for more merger research since the outcomes are inconclusive and need another perspective. Sidorov (2003) stated that superior leadership is essential in the grand scheme of mergers and has yet to be studied. Holten et al. (2019) conducted a study that supported the notion that management and leadership are essential drivers of positive change and success in mergers. Edward et al. (2017) conducted a healthcare improvement study to model how evidence can be modeled into practice and stated that healthcare is complex; thus, practical evidence or experience may take almost 20 years to implement into action. I addressed the need to understand the leadership perspective, which had not been researched to date.

Purpose of the Study

The purpose of this qualitative narrative inquiry was to explore the experiences of healthcare leaders related to merger decisions and potential strategies for the implementation of leadership in a merger context. I also provided information on shared leadership and the importance of building a successful foundation through a shared vision, core values, and guiding principles. These merger decisions occur even though the outcomes are inconclusive regarding patient access to quality care, costs to patients, population health, and industry impacts (Lapointe, 2018). The details of leadership lived experiences could be of great value to future healthcare industry leaders or those currently considering mergers (Jarouse, 2015).

With controversial merger outcomes (Greaney, 2018), the question becomes why healthcare leaders continue to participate in consolidations. Multiple searches via the Walden Library, Google Scholar, and other sources for similar studies showed few results related to the healthcare industry. I also conducted searches for healthcare mergers and merger impacts. Most sources found were newspaper articles, online statistics, online articles, and nonpeer-reviewed journals, suggesting that this could be an emerging topic with the changing tides of the healthcare industry (see Postama & Roos, 2016). Barilla et al. (2019) put forth a call for leadership to forge success, emphasizing a need for investigation into effective health policies and innovations and confirming the need for this research.

Research Question

What are the experiences of healthcare administrators (leaders) who have led decisions to merge hospitals or community healthcare organizations?

Interview Questions to Guide the Narrative

I sought an expert opinion on research methods from three experienced researchers to provide comments on the method of research used, the development of the interview questions, and the analysis methods applied in the study. To this end, I conducted interview pretesting, where the interview questions were provided to the expert researchers for opinion and guidance. The expert reviewer then analyzed the interview and provided areas needing changes to ensure the participants' clarity. The feedback was helpful as it ensured the interview questions were clear and concise and addressed the research problem. Feedback on the methods used for data analysis and

collection of data was also helpful as it allowed me to incorporate feedback in the methodology and during the data analysis phase of the study.

The incorporation of feedback led to the following interview questions:

IQ1: What type of merger was it?

IQ2: What was your role in the hospital or healthcare merger?

IQ3: What guidance were you provided to assist in the merger process?

IQ4: What was your experience from the decision to merge through completion?

IQ5: What are some lessons learned from the hospital merger process?

IQ6: Can you share your perspective on the merger process?

IQ7: What knowledge or expertise should a leader have prior to embarking onto a merger?

IQ8: What suggestions would you recommend to future leaders embarking upon a merger?

IQ9: Would you have found value in training to prepare for mergers as a leader?

IQ10: What would you have preferred to know in preparation for such an endeavor?

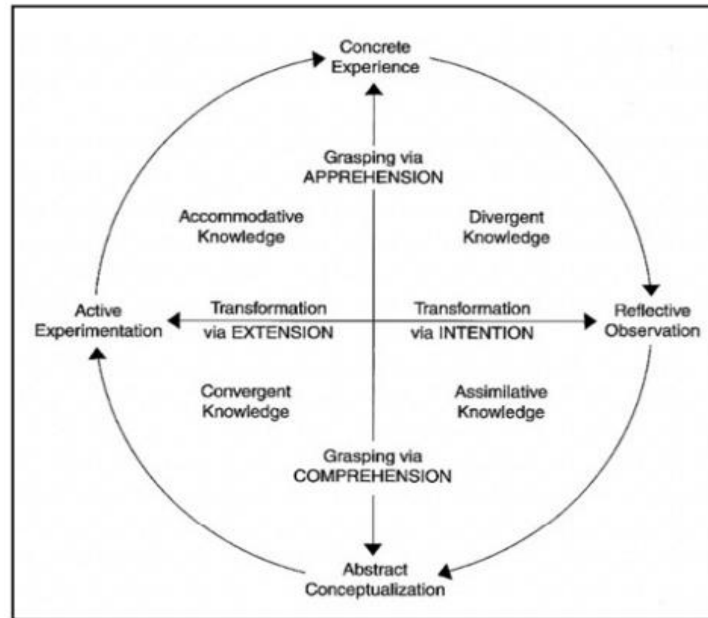
Conceptual Framework

The conceptual framework guiding this study was the observational experiential learning theory. Johnson (2020) explained that observational experiential learning theory is a conceptual model based on Kolb's experiential learning theory. Observational

experiential learning (OEL) theory can explain transforming experiences through knowledge, allowing for a holistic learning approach (Cherry, 2019). This theory emphasizes the many factors that influence the learning process: emotions, cognition, elements of the environment, and experience (Cherry, 2019). Kolb was influenced by the work of experiential learning theorists such as Dewey, Lewin, and Piaget (Cherry, 2019). Kolb is noted as the foundational scholar for experiential learning but cites many other scholars in his work, including: (a) Dewey for experiential education, (b) James for radical empiricism, (c) Piaget for constructivism, (d) Lewin for action research and the T-Group, (e) Vygotsky for the proximal zone of development, (f) Rogers for self-actualization via the process of experiencing, (g) Freire for naming experiences in dialogue, (h) Jung for the development from specialization to integration, and (i) Parker Follett for learning in relationships and creative experiences (Kolb, 1984). Figure 2 shows Kolb's four-sectioned feedback look, which is the model for my research by showing how to observe lived experiences to learn from or assimilate knowledge, then conceptualize the experience data into active experimentation that will bring about the grasping of knowledge or the ability to have learned from another's experience.

Figure 2

Feedback Loop Containing Four Stages of OEL



Note. From Experiential learning cycle by Kolb (1984)

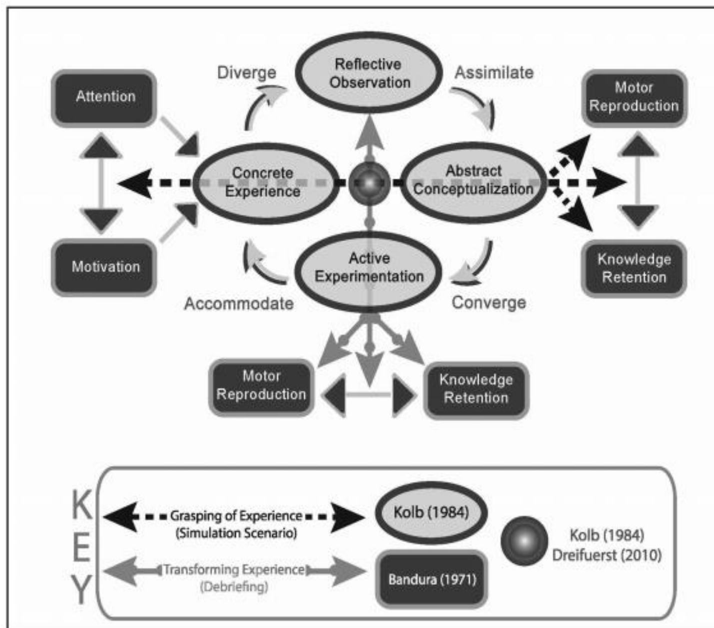
Overall, the chart depicts the feedback loop containing the four stages of OEL, including concrete experience, reflective observation, abstract conceptualization, and active experimentation, and the types of knowledge that arise at the intersections of these processes.

Johnson (2020) explained that observational learning could be experiential and active for both participants and observers. In addition to this information, researchers identified brain-based learning as an emerging form of learning. This new framework is believed to have been developed by merging debriefing and simulation knowledge for learning outcomes from both learners, supported by empirical testing (Johnson, 2020). Social cognitive and social learning theories were the guiding frameworks for vicarious

learning, observational learning, mimicry, visual learning, or imitation. Social cognitive theory, conceived by Miller and Dollard in 1941, suggests that some portions of an individual's knowledge acquisition are directly related to observing others through social contexts (Miller et al., 1941). Social learning theory, refined by Bandura, is a theory that couples learning processes with social behavior (Grusec, 1992). This theory states that an individual or organization can acquire new behaviors by observing others (Grusec, 1992). In this context, the recent spree of mergers could be the social context by which healthcare leadership observes to learn and acquire new behaviors. Johnson concluded that further theoretical support and research were needed to determine the value of the observer role, which differs from that of the participant but is still crucial to the learning experience. See Figure 3 for a synthesis of these theories and influences on OEL. Johnson's concept is most beneficial to study lived experiences in healthcare leadership and was the base model used for research.

Figure 3

Observational Experiential Learning Framework



Note: *Reproduced from Johnson (2020).*

The merger phenomenon is a societal and cultural issue; social theories were reviewed. Functionalism is how society seeks equilibrium or stability (S. Brown, 2014). Functionalism will only drive minimal change to achieve a nice societal change to be functional. Social constructionism is also a relevant theory, as it looks at what society gives value to versus what value these things equate to (S. Brown, 2014). Conflict theory is relevant when one group wants to change and the other is content with the status quo. Still, far too many needs must be addressed in the healthcare context for this theory to be practically applied to this research (see S. Brown, 2014). Symbolic interactionism was initially chosen as a framework for this research because leadership behaviors are the primary force driving the impact on merger outcomes and the increase in merger numbers

(S. Brown, 2014). After reviewing these theories and looking at the definitions of each theory, I determined that the best way to examine the root cause of this societal issue is to explore the lived decision-making experience of healthcare leaders based on Kolb's OEL theory.

OEL theory is instrumental when studying the effects of an individual's experiences and how that experience drives or impacts others, society, the community, or organizations (Johnson, 2020). Using OEL theory helped me explore the merger decision-making process and how these mega-mergers evolve from leader experiences. OEL comprises four phases, forming a feedback loop to inform future learning and development. These include concrete experience, reflective observation, abstract conceptualization, and active experimentation (Figures 2 and 3). The interactions between these stages result in discrete types of knowledge, depicted in Figure 2. The processes linking these stages and the processes are summarized in Figure 3. Kolb (1984) argued that for effective learning to occur, the learner must go through the entire cycle. He further recognized that this could present a challenge, as many learners favor individual parts of this process and resist completing the whole cycle. OEL theory is significant in providing a holistic model of learning and growth that is not linear but follows a cycle whereby previous experiences influence future directions (Kolb, 1984). This philosophy of learning is neatly juxtaposed against the process of narrative inquiry used in this study, which facilitates reflection on an experience and abstract conceptualization as a strategy to improve future outcomes, in this case, related to successful healthcare mergers.

Nature of the Study

The nature of this study was a qualitative narrative inquiry approach to explore the experiences of hospital leaders who have been part of the formation of new healthcare systems or mergers that have taken place in New England. Narrative inquiry is a vital avenue to understanding experiences, according to D. J. Clandinin and Connelly (2000) and J. Clandinin (2007), because I could learn from the participants in a reflective and recollective manner, with the participants being expert sources of the knowledge. Abutabenjeh and Jaradat (2018) demonstrated the relevance of a research design I used in this study, which consisted of conducting interviews with hospital leaders involved with healthcare mergers of any size within the past 5 years. The population for this study included a hospital chief executive officer, a vice president, a chief operations officer, a chief transformation officer/senior executive, a chief strategy officer, and a board of directors/general counselors of healthcare organizations. Purposeful sampling consisted of participants per healthcare entity that had recently undergone a merger. Five organizations were represented in this sample. Leadership participants were contacted directly via email or in-person visits. Conducting the study allowed me to dictate the number of participants warranted as the study and the data unfolded (Merriam & Tisdell, 2015).

Narrative inquiry was the chosen approach, as it helped facilitate a natural experiment through which I collected data on social interactions, experiences, relationships, behaviors, and decisions for why hospital mergers emerge via leaders' experiences through observed realism (D. J. Clandinin et al., 2018; Karahanna et al.,

2018). Interviews were recorded via Zoom and Microsoft Teams, transcribed via Otter.ai, coded line-by-line manually, and analyzed using Atlas.ti. Researchers using narrative analysis explore and code the narratives, as N. James (2018) described in her recommendations for effectively conducting narrative analyses. I identified specific themes and coded them using the participants' language. Interviews were analyzed multiple times to appreciate the emergence of relevant themes and subthemes fully. These were then compared across interviews to create a proposed management framework illustrating shared leadership strategies resulting in effective or ineffective healthcare mergers. This analysis sheds light on this increasingly common occurrence and offers insight to healthcare leaders considering mergers.

Definitions

The following definitions are of words and terms that will assist readers in understanding types of mergers and terms that may be outcomes from mergers as this research is explored. Some explanations of various learning theories have also been added to these terms to help understand the differences between each type of learning. Knowledge of these terms will bring forth a better understanding and ease of reading this research.

Experiential learning theory: Experiential learning theory is a theory of learning by reflective experience narratives or storytelling, consisting of a four-step feedback loop including concrete experience, reflective observation, abstract conceptualization, and active experimentation (Kolb, 2015).

Grasping of experience: Grasping of experience is a concept developed by Brandon Kyle Johnson by combining Kolb's experiential learning theory with Bandura's social cognitive theory (Johnson, 2020).

Healthcare Leadership: In the context of this study, healthcare leadership includes individuals holding one of the following positions: hospital chief executive officer, president, chief operations officer, senior executive, or chief medical officer (Figueroa et al., 2019).

Horizontal merger: A horizontal merger is a merger between companies that produce or sell the same product or services. In this study, a significant horizontal merger of interest is the joining of multiple hospitals or healthcare organizations that are of like-industry on the same level and type that might otherwise be competitors (Nocke & Whinston, 2022).

Hospital Consolidation: Hospital consolidation is the affiliation, acquisition, or merger of two or more hospitals, physician groups, healthcare facilities and related organizations (Center for Medicare & Medicaid Services, 2023).

Mega-merger: The definition of a mega-merger is a merger that is large and complex, not just vertical or horizontal (Reiss & Pryor, 2019). It is further categorized as having a value of $20 billion or more (Barnes & Magnuson, 2021).

Merger: For this study, a merger is a transaction to collaborate between two or more healthcare facilities of similar size and likeness in a field or industry (going forward or backward, such as supplier or customer). There are four categories of mergers: mega-

mergers, vertical mergers, horizontal mergers, and market expansion mergers (Kumar et al., 2019).

Assumptions, Limitations, Scope and Delimitations

In the following sections, I explain assumptions, limitations, and delimitations that may impact or cause common challenges to this research and further prevent exploring the merger leadership experience phenomenon being studied. I also described the scope of the study. I attempted to expose any components that may have hindered the study, such as access or human deficiencies and also presented preventative measures I took to avoid these potential pitfalls.

Assumptions

The most central assumption in this study is that all participants responded and provided data willingly and honestly to the best of their recollections since this research was retrospective. The participant's recollection is considered valid but, for the most part, cannot be verified. The first assumption was that each subject approached to be a part of this study had the knowledge and expertise regarding healthcare mergers and had been a part of a merger within the past 5 years. Participants were screened to meet the selection criteria.

The second assumption was that each subject could remember the necessary details desired for this study and considered this valuable to the body of knowledge for future leaders and researchers. Effective participant recruitment was critical to the success of this study, and because participants were not compensated, I relied on the

assumption that healthcare leadership perceived participation in the study as being a valuable use of their time.

The third assumption was that each participant was honest regarding their experience and part in the merger endeavor. While I had no reason to believe that participants were intentionally deceitful, it is nonetheless possible that interviews contained inaccurate information. Inaccurate information may be the result of intentional misrepresentation of facts or may reflect the participant's genuine belief about a situation such that the interview is not objectively factual but is still reflective of the participant's lived experience (see Hudson et al., 2020).

Scope and Delimitations

The delimitations for this study were that the research is from the leader's perspective because their experiences and decisions are drivers of the merger phenomenon and organizational strategies. As such, additional perspectives from healthcare staff not in an upper-level management role were not considered for the present study. This study was also delimited to employees of hospitals in New England that have undergone a merger within the last 5 years. These limited perspectives may no longer be relevant due to changes in the merger process over time. However, this also excluded healthcare leadership that considered but decided against a merger and thus presented a biased view towards the lived experiences of leaders with a positive view of mergers. As the researcher, I was willing to include leaders involved with merger decisions before and after mergers. The scope of this study was to conduct thorough interviews virtually due to location limitations and coronavirus implications regarding

social distancing. Collecting storytelling information from pre- or post merger leadership in its entirety was the goal.

Limitations

Unforeseen limitations can include the participant responses and the ability to recall information in detail, not being sufficient for the study (Bergen & Labonté, 2020). For this reason, I only invited healthcare leaders who have been involved in a merger within the last 5 years to limit the effect of the passage of time on the quality of memories. Participant bias for mergers could also be a limitation based on their high-level position within the organization. As I used a participant selection criterion based on mergers that took place, it by necessity excluded healthcare leaders who considered but decided against mergers or those opposed to mergers in general. This perspective would be interesting to include in future research, pending an effective strategy to identify such individuals.

Relatedly, while participants were invited to be interviewed based on having been involved in a merger, not based on the fact that a merger has had positive outcomes, self-selection bias may occur if participants are more likely to agree to be interviewed if they feel their involvement with a merger was successful (Sutton & Edlund, 2019). Hospitals and leadership may also be concerned about confidentiality and not want to participate in the study, especially if the merger had poor outcomes. Conversely, this is not a significant limitation, as I aimed to identify common themes associated with successful leaders. However, the lack of a control group leaves the potential for false positives, as it would not be possible to differentiate between genuinely effective strategies and

strategies that leaders merely believe to have led to their success. Together, this may limit the generalizability of the data (Queirós et al., 2017).

Being a leader in healthcare and handling many tasks as part of the merger may not allow recollection of the most minute nuances that may occur during the merger experience. This study was limited to the lived experiences of leadership, which inherently neglects details related to tasks that may have been delegated to or otherwise handled by other staff. It is thus essential to recognize the leadership perspective as likely being most informative concerning big-picture decision-making as a part of the merger process and as having less utility concerning small details. Furthermore, the perspectives of other individuals, including nurses, doctors, and other administrative staff, have been investigated in previous studies (Rainesalo, 2019). While these narratives are highly relevant to the overall field and provide essential insights, they were outside the scope of the present work.

The participants' level of comfort with the study could also have been a possible limitation, causing possible unreliable data collection. The participant's comfort level is especially relevant because I used a narrative inquiry approach to interviewing participants. Conversations were participant-driven, which could have resulted in the exclusion of information that paints the company or participant negatively. Because the interview was standardized, this might lead to no difficulty comparing the findings across participants; this resulted in allowing the participant to direction the response narrative as planned.

Additionally, it was not easy to corroborate specific details reported by interviewees, as these were open to interpretation or simply not documented. Secondary documents, including merger applications and other publicly available resources, were used to the extent possible to corroborate facts reported by interviewees. When possible, multiple participants were interviewed from the same institution. Importantly, I had no reason to believe that interviewees were intentionally deceptive, as there was no incentive to present false information, and if anything, participants stand to benefit from being truthful in their contributions to the study (Hudson et al., 2020).

Significance of the Study

This study could be significant to the body of knowledge by adding research that presents the lived decision experiences of leaders that may impact the merger phenomenon from the leadership perspective in New England. The rationale underlying leadership decisions to merge to provide population health services, quality care, operations, and remain competitive is a gap in this area for understanding fundamental driving forces. The findings could lead to positive social change in approaching quality care, population healthcare, strategic operations, and hospital mergers. In response to the aging population of the United States and the increasing political interest in healthcare, it is imperative to focus on strategies to improve the healthcare system (Yeganeh, 2019). Mergers may lead to improvements in healthcare costs and quality of care but can just as easily result in the opposite, indicating a critical need for increased attention to the factors underlying the success or failure of these endeavors (Yeganeh, 2019).

Significance to Theory and Practice

The healthcare industry faces numerous challenges, such as the ability to provide the surrounding community with quality care, competition with other hospitals, healthcare costs, and consumerism, which has led many formerly independent hospitals to merge into healthcare systems. Leadership responsibilities come with many challenges and concerns that could be potentially alleviated with better knowledge of merger nuances and historical data regarding leader decision-making experiences. This knowledge could be valuable to the actions of future healthcare leaders and enlighten current leaders. Leaders' decision-making experiences in handling complex problems could be a vital part of operations and crucial to the success of hospital leadership. Hospitals and healthcare leaders are challenged to provide quality healthcare accessible to the community, positively impact the industry, and remain competitive (L. Dafny et al., 2016; Hayford, 2012; Kacik, 2018a, 2018b). This narrative inquiry could reshape the future of population health and the industry by avoiding pitfalls such as incomplete cultural integration and variations in the quality or nature of care (Sanborn, 2018).

Significance to Social Change

I developed this study because increasingly common hospital mergers have begun to change the face of the healthcare industry in New England. Scholarly desire to understand how the lived experiences of healthcare leadership bring forth mergers prompted this research study to be conducted on experiential learning (Moseley et al., 2019). A greater understanding of how hospital leaders work through operational decisions may impact addressing population health. The community could be provided

with a better quality of care. Leaders will be more likely to make knowledge-driven decisions using outcome-based and theory-supported examples based on what is proven to work and what may not work to improve the health of society. These leaders may be better equipped to handle social change with this knowledge.

Summary and Transition

The increasing complexity of mergers in the healthcare industry challenges healthcare leadership. Understanding and learning how leadership addresses these new industry cultures can be valuable to healthcare leaders who may also face these challenges and will be looking to the research for knowledge on how to meet these decisions and the outcomes historically. Leadership's ability to manage change and plan successfully during integration and collaboration will set the tone for their future. In Chapter 2, I add information and review literary knowledge that has been found to date regarding mergers, healthcare leadership, frameworks, narrative inquiry, and experiential learning.

Chapter 2: Review of the Professional and Academic Literature

In this study, I focused on healthcare leadership's experiences regarding decisions regarding mergers leading to changes and trends in the healthcare industry. Therefore, the focus of this literature review was the need to conduct a narrative inquiry into the lived experiences of these leaders and their decision-making process related to healthcare mergers because they impact population health, healthcare quality, and patient costs. Research shows that mergers may only sometimes improve the quality of care, decrease patient costs, or improve population health (Chan, 2018). Still, mergers continue to be a chosen approach by many healthcare leaders.

The purpose of this qualitative narrative inquiry was to explore the experiences of healthcare leaders related to merger decisions and potential strategies for the implementation of leadership merging tasks. This study also provided information on shared leadership and the importance of building a successful foundation through a shared vision, core values, and guiding principles. However, the outcomes have been inconclusive on patient access to quality care, costs to patients, population health, and industry impacts (Lapointe, 2018; Westra et al., 2022). In this review, I first discuss the researcher search strategy and examine the conceptual framework chosen for the study. Second, I reviewed the literature review section's relevant information regarding hospital mergers. Next, I include a summary of the methodology used in the study, which is expanded upon in Chapter 3. I also provide a discussion of the context of the study. Lastly, Chapter 2 concludes with a summary of the findings presented in the chapter.

Literature Search Strategy

To research topics relevant to this study, I accessed Google Scholar, Walden University Library, Journals, News articles, and government documents. Keywords, search terms, and combinations of search terms used were: *healthcare mergers*, *hospital mergers*, *healthcare leadership*, *leadership, mergers impact on healthcare*, *New England, narrative inquiry*, and *experiential learning theory*. Many results were not relevant to the research, and some research was not similar or applicable to any of the results displayed from the keywords or search terms. As time passed, recent dissertations were written with analyses like this study in 2020. However, the body of knowledge was not sufficient in general, representing a significant opportunity for the study.

Table 2

Literature Search Results

Search parameters	Walden Library	Google Scholar	Relevant articles
Healthcare mergers, New England, and leadership experience	612	17,400	15
Healthcare mergers and leadership experience	2,883	16,900	5
Healthcare mergers and leadership experience, and Walden University Research publications only	0	3,490	4
Hospital mergers (2017-2022)	1,699		17
Experiential learning (2017-2022)	65		12

Conceptual Framework

The conceptual framework grounding this study was the OEL theory explained by Johnson (2020), whose model is based on that of Kolb, which describes transforming experiences through knowledge and allows a holistic approach (Cherry, 2019). This theory emphasizes the influence of emotions, cognition, factors of environment, and expertise on the learning process (Cherry, 2019). Kolb was influenced by the work of experiential learning theorists, such as Dewey, Lewin, and Piaget (Cherry, 2019). Kolb noted the foundational scholars for experiential learning to be Dewey for experiential education, James for radical empiricism, Piaget for constructivism, Lewin for action research and the T-Group, Vygotsky for the proximal zone of development, Rogers for self-actualization via the process of experiencing, Freire for naming experiences in dialogue, Jung for the product from specialization to integration, and Parker Follett for learning in relationships and creative experiences (Kolb, 1984).

Experiential Learning Theory

OEL theory has been used to investigate various social phenomena. The theory has become increasingly popular as applied to management education, as it promotes a more inclusive, active learning environment than a traditional educational setting (Kayes & Kayes, 2021). OEL theory uses a multidisciplinary approach combining concrete experiences with abstract conceptualization to facilitate the development of expertise (Kayes & Kayes, 2021). The theory further emphasizes the importance of real-world applications during the learning process and considers learners' practical and theoretical needs as unique individuals approaching learning from discrete perspectives. Learners

can begin this process anywhere within the cycle, although the concrete experience phase is often considered the logical point of entry (Kolb, 1984).

Morris (2020) described critical characteristics of concrete experiences that can lead to experiential learning. These included: active participants (involved learners); place and time situated knowledge; novel experiences (exposed learners), which involves risk; real-world problems specific learning demands inquiries; and mediator of meaningful learning critical reflection (Morris, 2020). Kayes and Kayes (2021) described the significance of Kolb's four-phase learning cycle (direct experience, reflection, abstract thinking, and experimentation) as being especially relevant in the context of management education, as this way of thinking can have a critical influence concerning decision making and strategy creation. Experiential learning involves cycling through the four stages of learning in a systematic way.

Moseley et al. (2019) evaluated an educational program's existing environment involving a partnership between non-formal and formal educators. These authors supported Kolb's OEL theory as their pedagogical basis and framework to implement, design, and assess educators in the field for their research. The sociocultural constructivist theory was also described to learn about interactions and experiences. Moseley et al. conducted observations and interviews and characterized a collaborative framework to develop this research to improve student learning comprehensively.

Elliott et al. (2020) conducted a study in Scotland. They explored the lived experiences of frontline leaders assigned to integrate a single partnership transaction of health and social care services. The nature of their study was qualitative, and a survey

explored the scope of 22 leadership and management areas and expected transformational and transactional activities within the roles. The study recommendations were that more needed to be done to support leaders. They specifically recommended that a training program be created to help make partnerships a more successful strategic approach in the future, which is the goal of this study (Elliott et al., 2020). This strategic approach can be tied into the different stages of experiential learning theory to be effective at fostering collaborative relationships.

Other researchers have built upon experiential learning theory. Johnson (2020) researched and expanded upon experiential learning theory and developed the OEL theory. He also discussed social learning theory and social cognitive theory, which are vital to the research conducted by an observer of lived experiences. Johnson showed the importance of the observer or the researcher in studying lived experiences. He introduced Bandura's transforming experience as a derivative of Kolb's grasping experience via his newly developed theory. While Johnson focused on simulation, his discussed ideas could also be applied to other business process areas.

Researchers have also shown practice applications of experiential learning theory, which is particularly relevant for this study. Passarelli and Kolb (2012) conducted a research study to look at how experiential learning theory could be used to promote student learning and development in education programs. They noted that experiential learning theory is a process whereby knowledge is created through the transformation of experiences. Passarelli and Kolb stated that knowledge results from the combination of grasping and transforming experiences. They further outlined the various learning styles,

as Kolb (2007) outlined. They mainly looked at the application of experiential learning theory in education.

Experiential learning theory has been applied to problems in science and management. For example, Parahakaran (2017) looked at how experiential learning theory could apply to practical science and technology ethics. The author analyzed how experiential learning theories could contribute to implementing ethical behaviors in science and technology. One of the primary goals of educators is to help learners understand how life works and how these happenings can be explained using theories. Parahakaran emphasized the need for students to understand experiential learning theory and how it is applied to real-world problems. Hence, I used experiential learning theory to explain mergers in the healthcare industry.

McCarthy (2016) looked at how experiential learning theory can be applied in various fields of education to understand how students learn. McCarthy looked at several learning approaches, including personality, information processing, social interaction, and instructional preferences. The study analyzes these approaches in detail, and the best practices for using experiential learning theory in different fields are discussed. McCarthy further noted that future research needs to be conducted on incorporating more than one approach to learning styles. Notably, personalities, information processing, and social interaction are particularly relevant for the present study on mergers since collaboration between partners is necessary for a successful merger.

Narrative Inquiry

Narrative inquiry was the chosen framework of this research study. Narrative inquiry can only be discussed with the work of Clandinin. D. J. Clandinin (2019) wrote extensively on research narrative inquiry. The most pertinent area for this study is her study of personal practical knowledge. She provided examples of an educator's experiential knowledge as practical knowledge, shaping and acknowledging which conceptualization is developed. Clandinin also brought validity to reflective observations in research because one's experiences can educate another when one's story is told. I applied the conceptual framework of Clandinin's research in this study of healthcare leadership.

Husovich et al. (2019) provided the ideal process management framework (Figure 4) as a guide for others to effectively create process maps, implement optimal learning models, create process documentation, and continuously maintain process performance improvement. This framework is a practical example of how research can be used to immolate and be learned from or share knowledge of ways to learn, build, create, and sustain optimal process plans to teach others afterward. Husovich et al. concluded that the process management framework is an integral part of the steps to implement change with great organizational success, ensuring concise and clear procedural documentation.

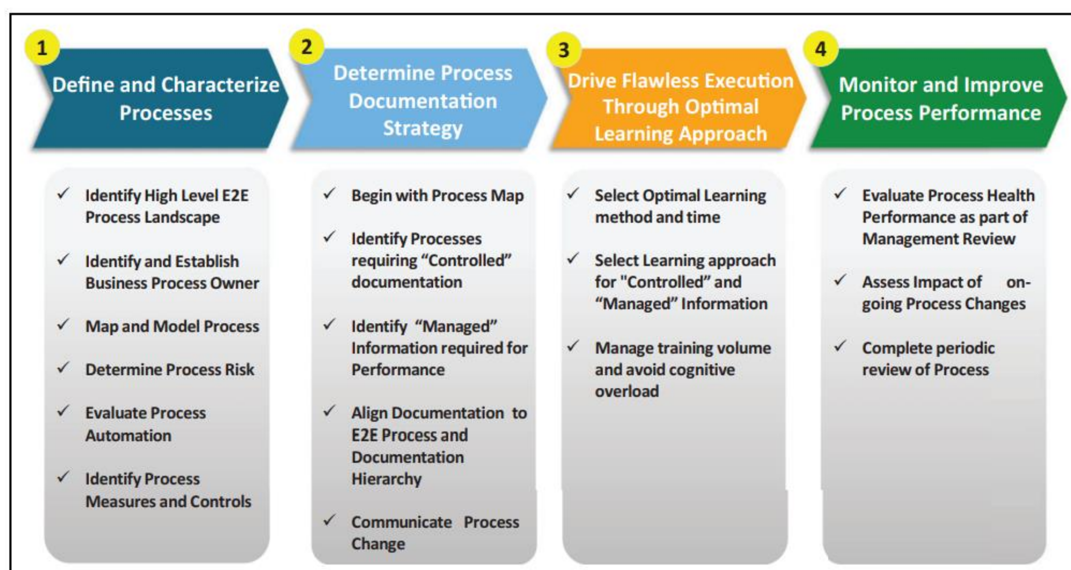
These researchers further concluded that excelling in execution is paramount for today's competitive healthcare landscape (Husovich et al., 2019). I used data collected through interviews via a narrative inquiry approach to conceptualize a process management framework underlying successful healthcare mergers, deriving from the

collective lived experiences of healthcare leadership. This method allowed for the participants' experiences to be clarified regarding hospital mergers.

Zuber-Skerritt and Abraham (2017) researched work-applied learning as a conceptual framework to develop managers as research practitioners. They aimed to introduce this conceptual framework as a reflective practice for positive organizational change with action learning, action research, and action leadership. See Figure 4.

Figure 4

Process Management Framework



Note. Husovich et al., (2019).

The research goals of this study were to examine healthcare leadership lived experiences within the hospital merger process. The original value that the analysis by Zuber-Skerritt and Abraham provided was knowledge on how to cultivate future leaders and managers. These researchers used aspects of epistemological theories: experiential learning theory,

phenomenology, critical theory, grounded theory, strengths-based theory, work-applied learning, and reality.

Literature Review

This section of Chapter 2 is designed to add context to why it is necessary to study leadership decisions behind hospital mergers. I review the scholarly literature related to hospital mergers in the following manner. First, healthcare leadership and mergers are discussed to understand what leadership decisions underscore hospital mergers. Second, I discussed the crucial difference between hospital mergers, the topic of this study, and hospital collaborations. Third, I illustrate examples of successful hospital mergers, as well as examples of hospital mergers that failed, while presenting the reasons for success or failure. Fourth, conflicts in the literature, especially concerning patient and merger outcomes, are discussed, as the primary reason for hospital mergers is to increase favorable patient and hospital outcomes. Finally, I include a discussion of the gap in the literature that the current study addressed.

Healthcare Leadership and Mergers

In the following section, I review the current literature found in a search for information related to knowledge about healthcare leadership experiences before, during, and after healthcare mergers. This strategy aligned with the purpose of this research to explore experiences in a recollective capacity to learn more to improve mergers or leadership organizational performance and operations in the future. Land (2020) called for disruptive, unconventional leadership approaches to healthcare to spur innovation. An example of this is the potential for a healthcare world without partnerships. Land’s

research is relevant to the study being conducted and expresses the need for leader knowledge and experience. The most critical takeaway from this research is that leadership is key to responsive care delivery system responsiveness (Land, 2020).

Healthcare leadership must contain education, experience, and exposure amongst other qualities. Leigh et al. (2017) studied a healthcare leadership conceptual development model from a multidimensional perspective in the United Kingdom (UK). The authors identified an approach they believed was necessary for effective leadership learning and teaching via the leadership qualities framework. They used the five Es to approach learning (examine, education, experience, exposure, and evaluation) as critical elements of their theory. Their methodology was to conduct interviews following a letter of invitation. Discussions were audio-recorded and transcribed verbatim for coding, and transcripts were thematically analyzed. This research is helpful as their conclusion found evidence-informed suggestions for practice-based pedagogical principles for leadership development as a best practice model.

Leadership is necessary for successful mergers. Barilla et al. (2019) called for bold leadership to transform healthcare, which has been said about mergers. Therefore, the leader's role is highly pertinent to the nuances of healthcare mergers and developing the healthcare industry's future. Leaders are the change agents that drive mergers and healthcare at many levels. Leaders address challenges, provide innovative strategies to improve healthcare and find solutions to cost implications in healthcare (Barilla et al., 2019). Thus, successful mergers necessitate ensuring proper healthcare leadership.

The experience of leaders within an organization may vary regarding a single event. Nelson-Brantley et al. (2018) used this method to explore how and why questions regarding a specific event from the perspective of multiple levels. They collected data from employees at a small midwestern hospital that had remained independent during mass mergers. This data collection approach is conceptually like the author's exploratory research, which is almost mirrored as this study looks at various managers from the perspective of leaders within the New England region. Similarities between this and my research were that invitations were sent to participants and that interviews and observations were conducted regarding retrospective thoughts on changes to organizational structure. Themes and subthemes were collected for organizational learning and organizational readiness (Nelson-Brantley et al., 2018). This work has important parallels to this present study, as I approached multiple perspectives by interviewing leaders from the same organization.

Kovarik (2016) believed leadership should commit to participating organizations in mergers. The authors argued that commitment is critical to merging cultures as they build a focus for the future and combat the many challenges associated with horizontal mergers. Kovarik stated that leadership is fundamental to integration success. The current research agrees with Kovarik’s statement that leadership is essential to the success of change within any healthcare organization (Kovarik, 2016).

Mergers can fail when healthcare leaders don't have the proper knowledge or strategies. Another problem healthcare leaders face is the lack of strategies or training to maintain healthcare business operations before or during a merger or any other change

initiatives (Hughes, 2020). Hughes (2020) elaborated that an overwhelming majority of organizational unions fail and that a proactive approach to confronting potential setbacks and maintaining an open line of communication leads to better outcomes. From Hughes research data, the exploratory research that I conducted aims to enlighten future leaders with beneficial information to provide guidance during the merger process proactively.

S. F. Brown (2020) conducted a doctoral dissertation on healthcare leaders' strategies to use successful change initiatives. Brown reported a 70% failure due to poor design in the execution by the healthcare leaders, as well as a critical role for communication and strong leader involvement in successful strategic change initiatives. This study is pertinent in that, once again, the importance of the leader's actions in implementation was identified, and the impact on the success or failure rates depends upon the knowledge, skills, and planning a leader has in his experience toolkit. This research is highly likely to translate into merger decisions, as these are effective strategic change initiatives implemented on a vast scale.

McAlearney (2008) interviewed 200 healthcare management respondents over 4 years to devise how leaders impact the organization, the workforce, expenses, and strategic priorities. The study demonstrated a valuable role for leadership development programs in increasing efficiency and outcomes and proposed several strategies for expanding the implementation and utility of these programs. This study's methods and overall objectives are highly like the process of the present work designed to precisely assess the New England healthcare leadership in the purview related to mergers. McAlearney directly conveyed the importance of leadership during mergers and every

aspect of healthcare operations and decision-making, further supporting the importance of the present work.

Mergers and Collaborations

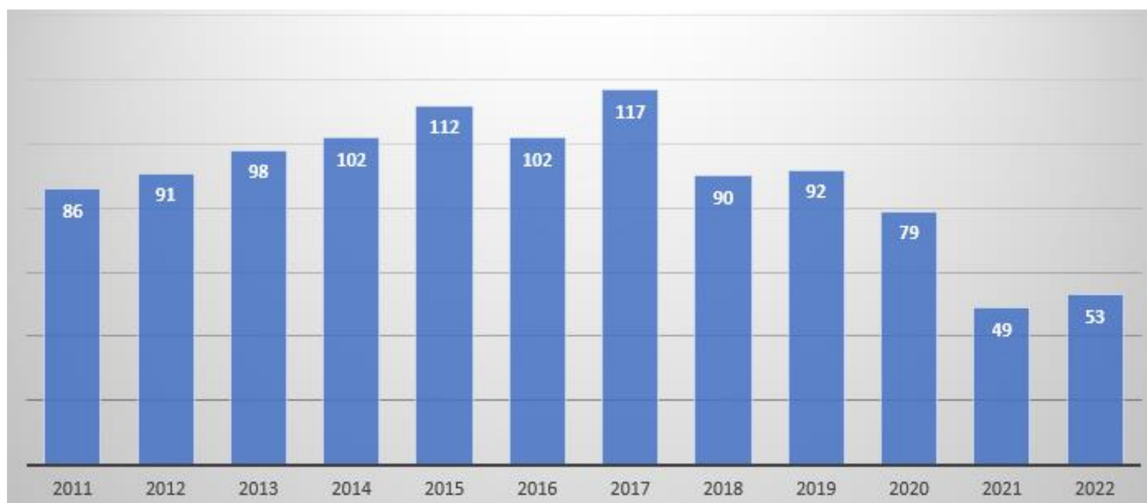
Furukawa et al. (2020) provided supporting data regarding vertical mergers and physician integration into healthcare systems between 2016 and 2018. These authors recognized that merger research was standard and that physician data had been reviewed extensively. Therefore, these authors researched another branch of the healthcare merger dynamic. The merger has many nuances and facets, which is why this research is significant in studying the lived experiences of the leaders responsible for mergers. Furukawa et al. (2020) reported an increase in United States healthcare systems in 2016 from 626 to 637 in 2018, with a 29% increase in physician mergers. Xu et al. (2015) provided merger data over five years and reviewed the potential hazards of hospital consolidation in the new healthcare landscape of increasing mergers. These authors introduced the problem of possible monopolies in the healthcare industry, which could negatively impact patient care and prices for treatment. Consolidation arguments were the focus of this article because positives and negatives were discussed to bring light to opposing views. The article by Xu et al. (2015) was beneficial as all sides should be addressed in research. This research concluded that integrated hospitals should create coordinated care for all communities, have opportunities to compete, be transparent with prices, and have quality outcomes because achieving these goals is vital to maintaining functioning healthcare systems. However, the authors did not explicitly discuss the importance of leadership decisions in driving mergers or appropriately managing their

outcomes; this is an essential factor that should be addressed, considering the importance of adequately handling merger dynamics. The data was highly significant to the research being conducted for this study, and this information supports the history of merger growth and the birth of the mega-merger.

Other researchers have examined challenges with different aspects of hospital mergers. For instance, Rainesalo (2019) conducted a similar research case study on post-merger organizational integration between management and acquired employees. This study was experience-based at a large healthcare organization in Finland. Pre-merger due diligence was assessed with the integration planning. Importantly, communication was significant to the study. Rainesalo's findings described adequate addressing of communication and cultural issues as critical to merger success. These findings are significant because poor management or leadership when preparing for a merger could harm the partnership's success and add opportunity costs to the organization (Rainesalo, 2019). I expanded upon these findings by focusing specifically on the experiences of healthcare leadership, broadening the proposed study's scope to include several organizations.

Figure 5

United States Merger Deal Volume



Note. Figure Reproduced from Singh (2022)

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Klar (2018) authored an article regarding post-merger integration in which he provided advice on achieving success in consolidating organizations from the perspective

of an organizational leader. His suggestions regarding value creation goal setting, promoting high satisfaction levels, delivering high-quality care, and high-efficiency outcomes are positive additions to this study. Also, he recommends better planning processes and clear communication; with complete transparency, integrated systems may obtain acceptance and achieve wanted outcomes (Klar, 2018). Applying these considerations to the specific case of mergers of healthcare systems will be of interest to this study.

In 2020, Vitale wrote about mega healthcare mergers amidst major economic jitters having burgeoning growth despite depleting payer mixes, medical reform, and reimbursement cuts. Vitale (2020) discussed the opportunity to improve operating margins and performance via mergers by healthcare leaders. The research that Vitale (2020) found was the belief that merging with other organizations would be the key to future success and provide leverage in acquisition for economies of scale (Vitale, 2020). This article demonstrates that healthcare mergers can be extraordinarily successful if handled appropriately, validating the need for research into the best methodology to achieve this outcome. Furthermore, the article supports the importance of healthcare leadership when mergers are being planned and implemented.

Also, in 2020, a study was conducted by Dalia (2020) regarding a mega-merger, which this author called “the colossus with the cult following” due to the subsequent increase in the number of mergers of immense size (p. 19). Dalia (2020) documented the rising costs of healthcare post-merger, the lack of cost-containment being an unfulfilled promise, and no evidence was found of any improvement in the quality of care for

patients, as this research concluded. Thus, this example serves as a counterpoint to the Vitale study, demonstrating the potential for mergers to be unsuccessful and emphasizing the need for research into effective leadership strategies to prevent this.

Examples of Successful Hospital Mergers

There have been thousands of hospital mergers in the U.S. However, few are researched for their outcomes and level of success. Therefore, this literature review overviews two of the most prominent and studied hospital mergers of: (a) Massachusetts General Hospital (MGH) and Brigham and Women's Hospital (BWH) and (b) New York Hospital and Presbyterian Hospital.

MGH and BWH Merger

In 1994, MGH and BWH merged to form Partners Healthcare, known today as Mass General Brigham Following (Lai et al., 2020; Melvin, 2018). According to Kastor (2001), the merger was successful because both institutions shared similarities and disparities, which must be considered. Each had the same objectives, excelled in clinical care, research, and teaching, and was financially successful (Kassirer, 1996; Kastor, 2001). However, the merger had a few complications from the staff's perspective. Although there was some parity in the number of hospital admissions, there were differences in the two staff's working environments (Kassirer, 1996; Kastor, 2001). The atmosphere at MGH was more club or group-focused. The workers had a stronger sense of identity and self-assurance (Kastor, 2001).

Not all scholars agree that the merger was a success, despite Mass General Brigham being one of the world's most successful and skilled hospital systems (The

Editorial Board, 2014; Lai et al., 2020). In an article by The Editorial Board (2014) at the New York Times, it was argued that Massachusetts made a severe error in 1994 when it permitted the merger of its two most prominent (and expensive) institutions (MGH and BWH), which are connected with Harvard. According to investigations by the state attorney general's office, the merger gave the hospitals tremendous market power to raise the cost of healthcare in the Boston region by requesting high insurance reimbursements that had little to do with the complexity or quality of the service provided (The Editorial Board, 2014; Melvin, 2018).

Additionally, there was recent scrutiny surrounding Mass General Brigham's' attempts to further expand in the Commonwealth and its most recent failed mergers with South Shore Hospital in Weymouth, Massachusetts, and Hallmark Health System in Medford, Massachusetts (Melvin, 2018). The merger approval represents a significant victory for Partners. The Massachusetts Attorney General filed a lawsuit on behalf of the state in reaction to these agreements, claiming that Partners used unfair business practices to compete (The Editorial Board, 2014). Partners or Mass General Brigham settled with the state attorney general over South Shore in response, which a state judge ultimately rejected. Compared to Commonwealth Hospitals, a rival, the cost of care at Mass General Brigham's hospitals and projected total cost hikes for insurers and customers were significant issues behind the failed mergers (Melvin, 2018).

New York and Presbyterian Hospital Merger

The New York Hospital, established in 1771, and The Presbyterian Hospital, established in 1868, are two of the most prestigious hospitals in the United States (Kastor,

2001). Both institutions have a long and illustrious history of caring for the New York region. Because their campuses are located in different areas of Manhattan—The New York Hospital campus is located on the Upper East Side, and The Presbyterian Hospital campus is located in Washington Heights in northern Manhattan—their respective services, rather than competing with one another, complement and enhance one another (New York Presbyterian, 1998). Patients from the lower portion of Manhattan and many patients from Brooklyn and Queens have been treated at the New York Hospital. Patients from upper Manhattan, the Bronx, New Jersey, and the Hudson Valley have traditionally made up most of Presbyterian's patient population (Corwin et al., 2003; New York Presbyterian, 1998).

When the hospital merged with the other facility, it was confronted with several substantial obstacles, the most significant of which was the integration of its clinical operations with the other medical center (Kastor, 2001). Barriers to collaboration were highlighted in size, geographical distance, medical schools, histories, and cultures (Corwin et al., 2003). The hospital decided to implement service lines to enjoy the benefits of clinical integration without being required to force the consolidation of departments to bring about the necessary clinical alignment (Corwin et al., 2003; Kastor, 2001).

Examples of Failed Hospital Mergers

There are more failed hospital mergers than successful ones in the U.S. These failures are usually due to financial and policy disagreement or incompatibility. Similar to hospital merger success, research on specific case studies was scarce on failed hospital

mergers. Therefore, this section reviews two of the most researched failed hospital mergers, including: (a) Care New England and Lifespan and (b) Geisinger Health System and Hershey Medical Center.

Care New England and Lifespan

Unions and the leadership of the state's healthcare systems will need to develop a common goal for the state's healthcare system to construct a successful entity (Binder, 2022). In the long run, a proposed merger between Care New England and Lifespan to create an integrated academic healthcare system with Brown University could lead to reduced fragmentation and a coordinated effort to provide care south of Boston and north of New Haven (Binder, 2022). This perspective is gained by standing at an altitude of 30,000 feet. By the provisions of the state's Hospital Conversions Act, a decision is scheduled to be made around the middle of March once the investigation conducted by the Office of the Attorney General and the Rhode Island Department of Health has been concluded (Binder, 2022).

According to the allegations made in the complaint filed with the FTC, the proposed merger between close competitors Lifespan and Care New England would almost certainly reduce the number of competitors in the state of Rhode Island and 19 neighboring communities in Massachusetts for inpatient general acute care hospital services and inpatient behavioral health services (*Statement Regarding Termination of Attempted Merger of Rhode Island's Two Largest Healthcare Providers*, 2022).

Geisinger Health System and Hershey Medical Center

Officials of the Geisinger Health System in Danville, Pennsylvania, and the Hershey Medical Center (HMC) tried to combine their two institutions in 1997 (Mallon, 2006). They tried to build an organization that could thrive in a changing setting (Lineen, 2014). The merger was successful for a total of three years. However, almost immediately, tensions began to surface in many different facets of the management and operations of the health system due to financial and leadership disputes (Mallon, 2006). The turbulent past and final demise of the Penn State Geisinger Health System were significantly influenced by three interconnected problems: (a) dysfunctional leadership, (b) mistrust among board members, and (c) various organizational cultures. Their endeavor was motivated by a desire to create a nationwide paradigm for healthcare delivery (Lineen, 2014). Unfortunately, they failed in their efforts, as previously documented in the Geisinger Health System and Hersey Medical Center deal, where later conflict between management and operations led to its demise (Mallon, 2006).

Academic health centers and tertiary care were in danger. Although HMC and Geisinger were financially sound at the time of the merger, the executives of both organizations accepted projections that neighborhood hospitals and physician associations would unite to become extensive healthcare systems. In the case of Penn State Geisinger, underlying market forces are expected to favor a more extensive system with a sizable clinic, three hospitals, more income, lower costs, more capital, and more patient referrals. The aims of this system merger were met. However, additional

difficulties were brought on by the systems' significant cultural characteristics and a lack of support among neighborhood healthcare professionals (Lineen, 2014).

Leadership could not persuade internal stakeholders of the merger's benefits, and management carried on, enabling redundant programs to continue. Healthcare executives may want to study the lessons that have emerged in light of what happened with Penn State Geisinger (Lineen, 2014). Present leadership may not be capable of bridging cultural gaps, typical management may not be capable of reaching higher efficiency, and resistance among internal and external stakeholders can swiftly coalesce (Lineen, 2014; Sidorov, 2003). Both institutions desired to increase their clinical operations, enhance competitiveness, and make financial savings. For this purpose, they anticipated early savings of up to $20 million and projected savings of more than $100 million throughout the first three years of the merger (Mallon, 2006; Roma, 1997). Curiously, officials also stated that there would be few employment cuts and no existing facilities would be closed (Roma, 1997). Even if the two groups shared similar objectives, a simple analysis of their justifications shows that their primary focus areas differed substantially (Mallon, 2006). Geisinger's goal was to grow its clinical programs into new markets.

In contrast, Penn State aimed to acquire a financing source for its academic purpose while leveraging its health plan as a critical commercial strategy. Some decision-makers later realized these various objectives. Although PSGHS's organizational design created the impression that the board and executive leadership were on an equal footing, it was unclear if this was the case after the merger. Almost everyone questioned about the events said the solution was no looking back. The turbulent past and eventual demise of

the Penn State Geisinger Health System were significantly influenced by three interconnected problems: dysfunctional leadership, mistrust among board members, and various organizational cultures (Mallon, 2006).

Conflicts in the Literature

A substantial number of quantitative research regarding the number of healthcare mergers that have taken place in recent years contributes to the effects these have had on patient outcomes and hospital finances. As described above, individual case studies have demonstrated hospital mergers' positive and negative impacts (Dalia, 2020; Vitale, 2020). Interestingly, despite mixed findings related to the impact of mergers on these factors, mergers continue to take place and grow larger (Dalia, 2020). Strikingly, most findings indicate that most hospital mergers fail (S. F. Brown, 2020; Hughes, 2020). Hughes suggests that the failure of most healthcare mergers may be related to inadequate leadership. It is plausible that leaders who choose to move forward with a merger are confident that their leadership abilities are above average and that they will thus be more likely to be successful. This possibility has not been investigated and represents a significant potential outcome of the present qualitative study exploring the lived experiences of hospital leadership involved in mergers. State merger reviews must address the root issue of excessive market concentration to limit market power effectively. This can be done by blocking anticompetitive mergers, imposing structural remedies like divesting facilities, or attaching conditions meant to prevent market power abuses like anticompetitive price increases and anticompetitive contract clauses (Gudiksen et al., 2021). Because federal antitrust enforcement for hospital mergers is

constrained by financial limitations, less flexible merger review power, and a lack of understanding of local market realities, states might play a crucial role in correcting badly functioning hospital markets (Berenson et al., 2020). Moreover, having an efficient antitrust enforcement framework is essential given the growing body of evidence demonstrating the anticompetitive effects of hospital merging (Fulton et al., 2021).

Patient Outcomes

Hospital mergers are also likely to hurt patient outcomes; data collected over 15 years from California hospitals indicates that local hospital mergers were associated with an almost 4% increase in inpatient mortality for patients with heart disease (Hayford, 2012). While the potential impact of increased travel time due to facility closures has been proposed as a possible intervening variable leading to increased mortality, it is unclear whether this is also related to other merger-related factors, such as decreased quality of care or inefficient management. It is also unclear to what extent hospital leadership is aware of this phenomenon when choosing to engage in a merger and whether or not this is a driving factor in making this decision. Because this study seeks to investigate the perceptions of hospital leadership during the merger process, it stands to address this conflict between the expected effects of mergers on patient outcomes based on the literature and the choice to proceed with this process.

No discernible changes in readmission or death rates were seen in another hospital or an acquired hospital; however, patient experiences were slightly poorer (Beaulieu et al., 2020; Gaynor et al., 2013). According to previous research, more competitive hospital markets typically produce better patient outcomes than less competitive ones (Bloom et

al., 2015). It is expected that certain purchased hospitals will have reduced rivalry after the acquisition; therefore, the minor reduction in patient-experience performance across acquired hospitals was not a continuation of prior trends and was not explained by changes in hospital patient populations (Beaulieu et al., 2020; Bloom et al., 2015). Patient experiences may be particularly impacted by diminished competitive incentives for hospitals to draw patients since they are, by definition, observable by patients as features of quality (Beaulieu et al., 2020).

From 2009 to 2013, hospital mergers and acquisitions were linked to a slight decline in patient-experience metrics, but there were no discernible changes in readmission or death rates at acquired institutions. Furthermore, according to Beaulieu et al. (2020), clinical-process performance effects at acquired hospitals could not be determined. Together, these studies show no proof of quality improvement by ownership changes (Beaulieu et al., 2020).

The current literature on hospital mergers and the potential negative consequences largely neglects to consider the current state of hospitals that engage in mergers and the likely outcomes should hospital leadership choose not to merge. For example, some mergers and acquisitions likely occur as a strategic move to increase the sector's dominance and negotiating power with insurance companies (Greaney, 2018). Alternatively, some healthcare mergers will likely be the last resort when an institution is struggling. In these cases, it may be challenging to ascertain whether the failure of a merger is the result of the process itself or an inevitability that the merger could not prevent. This qualitative study using a narrative inquiry approach leaves room to discuss

such influences. It could provide valuable insight into this gap in our understanding of why mergers happen and why they are not always successful.

Merger Outcomes

There is little understanding of the long-term consequences of healthcare mergers, especially the large mega-mergers that are becoming more common today. While this is beyond the scope of the present study, as it will require longitudinal study over the coming years, researchers should remain cognizant of this essential detail. It is reasonable to assume that the benefits of mergers may take many years to manifest and that restricting the analysis to the immediate effects of mergers may bias results toward adverse outcomes associated with the transition period.

This study provided insight into the perspectives of hospital leadership as they consider the short-term and long-term effects of mergers and their relative priorities. Excellent leadership will likely play an essential role in mediating these short-term effects of mergers. It stands to improve the transition by facilitating the integration of cultures and providing a shared vision for the future (Kovarik, 2016). Therefore, considering how hospital leadership prioritizes this transition period compared to long-term outcomes may be interesting. While not the goal of this study, the narrative inquiry approach leaves room for this to be addressed should leaders consider it an essential part of their decision-making process.

Gaps in the Research

The competitive impacts of hospital mergers are examined in several articles. The ones that use an event research technique are pertinent to this essay. For instance, Vita

and Sacher (2001) compared the post-merger pricing change of the merging hospitals to a control group using a "difference in difference" estimate. Other research, including those by Connor et al. (1998) and Krishnan (2001), examined pricing impacts across numerous mergers (Tenn, 2011). Beaulieu et al. (2020) demonstrated that hospital market consolidation has increased the negotiated pricing with private insurers, but little is known about the consequences on healthcare. Furthermore, nothing is known about how the recent wave of hospital acquisitions has affected the standard of treatment; these impacts may differ due to shifts in the healthcare industry (Neprash et al., 2017).

Numerous studies have demonstrated that hospital market consolidation has increased the negotiated pricing with private insurers, but little is known about the consequences on healthcare quality (Beaulieu et al., 2020; Neprash et al., 2017). Furthermore, little is known about how the recent wave of hospital acquisitions has affected the standard of treatment; these impacts may differ due to shifts in the healthcare industry. Thus, research is needed to clarify the role of leadership in the decision-making process regarding hospital mergers.

Hospital mergers face significant challenges. First, due to provider consolidation, more recent purchases have involved larger health systems, which may have various post-acquisition quality-improvement activities (Beaulieu et al., 2020). Second, the Affordable Care Act's payment changes, which boosted the incentive from quality improvement, have been used to hypothesize additional profits from mergers and acquisitions; however, actual data raises doubts about whether providers have consolidated to participate in new payment models (Neprash et al., 2017). Third, the

availability of information about hospital quality has risen, which can promote quality-based competition and raise market share for high-performing hospitals; as a result, a decline in competition may now be more detrimental (Neprash et al., 2017). Fourth, the pricing impact of each hospital merger is an empirical question since mergers of rival hospitals may lead to higher or lower hospital charges. Only a few studies have examined the past price consequences of hospital mergers (Haas-Wilson & Garmon, 2011). Thus, more research is needed to clarify this point.

According to Vita and Sacher (2001), a sizable price rise resulted from the merging of two nonprofit hospitals in Santa Cruz, California. Capps and Dranove (2004) examined a dozen mergers of rival hospitals in the late 1990s. They discovered that 75% of the unions led to higher price increases than the sample's median price rise (Haas-Wilson & Garmon, 2011). Retrospective studies of hospital mergers by L. Dafny (2009) and Krishnan (2001) have revealed that, on average, prices rise as a result of mergers involving rival institutions (Haas-Wilson & Garmon, 2011). Economic factors have been the primary focus of the work on the effects of hospital mergers (Giancotti et al., 2017). On the other hand, there is still a dearth of research detailing the effects of the merger on healthcare quality measures (Mariani et al., 2022).

Methodology

A quantitative methodology is appropriate for collecting data that can be numerically analyzed using statistics, while a qualitative method addresses how and why questions (Yin, 2015). This study seeks a deep understanding of the nature of the data. This study utilizes a qualitative rather than a quantitative method of data collection and

analysis. The methodology is thus largely open-ended and will evolve throughout the study in response to the nature of the data collected. This approach has advantages over quantitative research in that it recognizes nuances within the data collected and is more appropriate for analyzing complex systems of numerous interrelated variables (Yilmaz, 2013). While this approach to data collection offers a significant advantage concerning contextualization and interpretation of the meaning behind data, it also relies heavily on the researcher to appropriately interpret the findings of the study (Yilmaz, 2013).

With qualitative methodology being the chosen modality for this study, it was imperative to review other dissertations that used this study format. Dillard (2017) conducted a qualitative study on multiple case studies that explored the lived experiences of healthcare executives and leadership because the problem being studied was poorly understood. This study will use a similar methodological approach to interview subjects and characterize their lived experiences using a qualitative narrative framework.

de Kam et al. (2020) looked at regulations of hospital mergers from a quality care point of view, the study utilized a qualitative approach to collecting data. It drew 30 semi-structured interviews to conduct 30 semi-structured interviews with its participants. Another study by Lim (2014) looked at the impact of hospital mergers on staff job satisfaction using a quantitative method data in the study was collected from the annual National Health Service staff mergers compiled by the department of health. The study used observable factors that were likely to affect the merger decisions and selected three hospitals to act as a control group. Another study by Bašić (2021) utilized a quantitative approach while investigating the quality of healthcare in the aftermath of hospital

mergers. Bašić (2021) used hospital data from 2012 to 2019, two types of performance indicators were chosen. Finally, I looked at Westra et al., (2022) who utilized a mixed method research approach quantitatively they looked at the quality effect of all consummated hospital mergers between 2000 to 2014 in the Netherlands using 15 quality indicators. Qualitatively the study conducted three comparative case studies to examine how hospital leaders perceived the impact of hospital mergers. After analysis of all the studies, I used a similar methodological approach to interview subjects and characterize their lived experiences using a qualitative narrative framework.

Creswell and Creswell (2017) noted that qualitative studies differ from quantitative studies as they look at the ‘how's and ‘why's of a phenomenon being studied. This is one of the biggest strengths of qualitative studies for researchers as agreed by Anderson (2010). Anderson (2010) noted in his study that data from qualitative studies are powerful as it is based on human experiences rather than data obtained through quantitative methods. While qualitative methods have several strengths, their limitations cannot be ignored. Anderson (2010) posited that qualitative methods are heavily dependent on the individual skill of a researcher and can easily be influenced by a researcher’s biases. Furthermore, rigor is difficult to maintain due to the limited volume of data collected during the research process.

Context of the Study

The study's goal was to explore the experiences of healthcare leadership before and during healthcare mergers and focus on the integration process and finding common factors regarding strategies and maintenance of business operations. A greater

understanding of these experiences is pertinent to research into leaders' lived experiences and the causality of the future of mergers, which is constantly evolving. Hughes mentioned characteristics of hospital mergers being unique in various respects, such as location, size, resources, culture, and business process (Hughes, 2020). This research is aware of the nuances listed above and intends to address these factors with the explorations of the lived experiences of the study participants.

Summary and Conclusions

This chapter reviewed the literature required to support the study and to show that there are significant gaps in the available research. First, the chapter outlined the conceptual framework of Observational Experiential Learning for the study. Specifically, the theory highlights the value of practical applications in the learning process and considers learners' theoretical and practical demands as distinct persons who approach learning from different angles. Although the tangible experience phase is frequently seen as the logical point of entrance, learners can start this process anytime throughout the cycle (Kolb, 1984).

Next, the chapter reviewed the literature required to conduct the study. The literature shows that the rate of mergers had been on a steady climb until 2019 when the numbers decreased slightly in 2020. However, the complexity and size of these transactions continue to grow. The future of the healthcare industry has become more competitive, and it is thus more difficult for leadership to know how to compete. Additionally, the outcomes of mergers are mixed, with significant numbers of mergers

failing altogether or being associated with increased costs and poorer patient outcomes (S. F. Brown, 2020; Hughes, 2020).

It is thus unclear why hospital leadership chooses to proceed with a merger despite the considerable risk of it being unsuccessful. Leadership knowledge and experiences remain the key to the future of healthcare. Several studies have identified leadership as among the key determining factors in whether a merger will be successful (S. F. Brown, 2020; Kovarik, 2016). However, the perspectives of these individuals as they pertain to the decision-making process, motivating factors, and post-merger leadership philosophies are not well understood. Identification of leadership strategies that are more likely to be associated with successful merger outcomes is critical to the ongoing success of the healthcare system.

Investigating leaders’ experiences via a narrative inquiry is the best way to gain this valuable information, as this approach facilitates a natural, conversational interview that leaves space for interviewees to focus on factors that they perceive to be most important. Narrative inquiry provides important qualitative information that may be overlooked in a purely quantitative study. There is a clear gap in the literature when looking for the leader's perspective, especially with respect to this more nuanced information. Therefore, this research could extend knowledge in the healthcare merger discipline. Chapter 3 will provide a plan regarding methodology, research design, participants, data collection, and ethical considerations. This will include a thorough description of the interview approach and the rationale behind choosing this method,

additional details about the participant selection process, and a review of potential pitfalls associated with the chosen approach and how they will be mitigated.

Chapter 3: Research Method

The purpose of this qualitative narrative inquiry was to explore the experiences of healthcare leaders related to merger decisions and potential strategies for the implementation of leadership in a merger context. This study also provided information on shared leadership and the importance of building a successful foundation through a shared vision, core values, and guiding principles. Although the outcomes of merger decisions and how healthcare leaders choose consolidation are inconclusive concerning patient access to quality care, evidence supports the impact of healthcare leaders' choices on costs to patients, population health, and industry impacts (Lapointe, 2018). The details of leadership's lived experiences could be of value to future healthcare industry leaders or those currently considering mergers (Jarouse, 2015).

In Chapter 3, the methodology used in this qualitative narrative inquiry is presented. The rationale for choosing the qualitative methodology with the narrative inquiry research design was represented. The population, sample and sampling criteria are described. Next, I discuss the procedures for participant selection, recruitment and data collection, organization, and analysis. Issues of trustworthiness and ethical considerations are also presented.

Research Design and Rationale

A theoretical basis for this qualitative research methodology followed N. James' (2018) narrative inquiry and storytelling analysis. This method entails a fluid approach to research that responds to the interview and allows the conversation to occur naturally instead of being driven by a rigid set of predetermined objectives (James, 2018). In this

way, the interview structure is reflexive rather than prescriptive, allowing me to investigate unexpected and potentially novel areas of inquiry. I explored detailed accounts of a mega-merger case, which was afforded theory development through James' guidance and illustration. This method is a prime application for this research, as the experience and challenges are fresh in the minds of the leadership, allowing for a more complete and accurate story. A narrative approach to the merger phenomenon in the healthcare industry allowed me to explore possible strategy lessons learned in leadership decision-making (see Noon, 2018) that can be revealed with narrative construction and narrative analysis (James, 2018). The objective was to collect descriptive narratives that could be examined reflectively to develop improved practices and outcomes within the merger phenomenon, which is changing the healthcare climate.

The merger phenomenon is a societal and cultural issue; in determining an optimal strategy to assess this phenomenon, various social theories were reviewed. Functionalism is defined as how society seeks equilibrium or stability in society (S. Brown, 2014). Functionalism will only drive minimal change to come to a nice societal change, specifically, one that is functional. Social constructionism was investigated because it looks at what society gives value versus what value these things have (S. Brown, 2014). After reading about conflict theory, I noted that the current research on merger outcomes conflicts with why healthcare leaders choose to merge. This theory is relevant when one group wants to change, and the other is content with the status quo, but in healthcare, there are far too many needs to be adequately addressed using this theory. Symbolic interactionism was initially chosen for this research because of the nature of the

leadership behaviors driving the impact on merger outcomes and the increase in merger numbers. With all this information and looking at the definitions of each theory, symbolic interactionism is the best theory for this research, which is why the researcher needed to explore the lived decision-making experience of healthcare leaders (S. Brown, 2014).

While exploring merger experiences of healthcare leadership, I used narrative inquiry and Kolb's OEL theory to conduct my research. The OEL diagram shows that knowledge is obtained from reflection on experiences, which is their story to tell (Johnson, 2020). Narrative inquiry is the chosen approach, as this allows a natural experiment to obtain and collect data on social interactions, experiences, relationships, behaviors, and decisions for why hospital mergers emerge from leadership lived experiences through observed realism (Karahanna et al., 2018). Interviews were recorded, transcribed, coded, and analyzed using Atlas.ti. The narrative analysis was used to explore and code the narratives as N. James (2018) did. In brief, themes and subthemes were identified from the analysis of each individual interview using the interviewees' own language. These are likely to vary between interviews based on the direction of the conversation, as the objective of narrative inquiry is to allow topics to arise naturally (James, 2018). The same interview process was repeated for each interview to identify notable quotes and phrases and to allow themes to emerge. Finally, a summary of each interview was constructed from notes and by referring to transcripts of the conversations. Common themes were identified across interviews to arrive at generalizable conclusions for analysis.

Role of the Researcher

My role as the researcher for this study was to be in the observer role, as Johnson (2020) described, where both the participant and the observer play significant roles in the research being conducted. I had no clear biases as the researcher because the role was solely to take note of the responses provided by the participant. I guided the interview by asking the 10 questions listed below but otherwise allowed the participant to direct the interview according to what they believed to be truthful and relevant. Interviews were recorded with the participants' permission and transcribed verbatim to ward against any bias or errors. Researchers should follow the protocol and instruments provided by the academic institution to ensure consistency and standardization in research studies (Daniel, 2019). In research, the role of the researcher is the guardian of privacy for the participants as well as the ethical guide for the virtue of the data being collected. Following the interviews, I carefully analyzed the information gathered and constructed a common narrative to characterize each interview. Additionally, I ascertained common themes that were likely to inform both those involved in this study and other leaders of healthcare organizations considering mergers.

Methodology

The methodology I used for this research was to allow the nature of the study to take the reader on a journey to experience the premerger thought process that the participants experienced. Collecting reflective narratives was the goal, and analyzing these stories to gain information and learn from the participants was the basis of this research methodology.

Data was collected for this descriptive qualitative study through interviews with individuals holding leadership positions within healthcare organizations. Specifically, this included hospital leaders involved with healthcare mergers within the past 5 years. The population for this study included a hospital chief executive officer, a vice president, a chief operations officer, a chief transformation officer/senior executive, a chief strategy officer, and a board of director/general counselor. Purposeful sampling included at least one participant per healthcare entity that has recently undergone a merger. There were five participating organizations represented in this research study.

Conducting the study in this manner allowed me to dictate the number of participants warranted as the study and the data unfolded, according to Merriam and Tisdell (2015). Resources for this research came from pertinent healthcare merger applications, documents, and proposals that are available to the public. I also reviewed publicly accessible applications for mergers that have been submitted within the past 5 years. Interview questions that guided the narrative included the following:

IQ1: What type of merger was it?

IQ2: What was your role in the hospital or healthcare merger?

IQ3: What guidance were you provided to assist in the merger process?

IQ4: What was your experience from the decision to merge through completion?

IQ5: What are some lessons learned from the hospital merger process?

IQ6: Can you share your perspective on the merger process?

IQ7: What knowledge or expertise should a leader have prior to embarking onto a merger?

IQ8: What suggestions would you recommend to future leaders embarking upon a merger?

IQ9: Would you have found value in training to prepare for mergers as a leader?

IQ10: What would you have preferred to know in preparation for such an endeavor?

I discussed with the participants that if the conversation goes in another direction, the narrative nature of this study allows for this to occur, and it was encouraged. Efforts were made to include all research questions during the interview process.

Participant Selection Logic

Following institutional review board (IRB) guidelines and regulations for research participation, I recruited adult healthcare leadership. Participants were part of a hospital merger in the New England Region within the past 5 years. The sample size that was selected was 6 participants. Butina (2015) stated that there is not a straightforward sample size in qualitative research and that there are no set rules in qualitative inquiry. Also, Vasileiou et al. (2018) stated that sample size is contingent upon the number of factors relating to methodology, epistemological, or practical issues. The Northcentral University's Applied Doctoral Center stated in its academic guide that six to 10 participants are normal sample sizes for narrative inquiry (DeMarco, 2020). This sample size was chosen following Guest et al. (2020), who found that data saturation was

reached in 96% of interview-based qualitative studies after a sample size of 10 participants were interviewed. The initial participant selection process was based on research identifying recent mergers in the New England area to select healthcare organization leaders that have completed a merger within the past 5 years. The selected leaders who met the above criteria received a letter of invitation via email or other social media platforms to participate in this study. The initial invitation entailed an introduction of the student and the purpose of the research. After the leader agreed to participate, a package was provided with the interview protocols, consent form, and request to schedule the interview for 1 hour.

The primary type of data collection for this qualitative narrative inquiry is to conduct open-ended interviews. Participants were allowed to tell their stories as they recalled the experience taking place as true to form as possible. This form of data collection will provide multiple perspectives to find commonalities within the merger phenomenon.

Instrumentation

The sole data collection instrument was an interview protocol I devised. The interview protocol was sufficient to answer the research question for two reasons. First, I created the guiding interview questions considering the material covered in the literature review and through the lens of the conceptual framework, observational experiential learning theory. Second, an expert panel reviewed the guided interview questions, and their feedback was incorporated to generate the final interview protocol. Content validity was ensured through purposeful sampling of the participants, as well as through the use

of verbatim quotations from the participants to ensure their narratives are accurately described.

The interviews were video- and audio-recorded via Zoom or Teams software data collection instruments. The modality was at the discretion of the participants, and permission to record was requested for permission at the time of consent. I used Otter.ai to transcribe the interviews and then verified their accuracy by comparing the Otter-derived transcript to the audio recordings and by sharing the transcribed notes with the participants.

Procedures for Recruitment, Participation, and Data Collection

The first step in recruiting participants was sending an electronic letter to them directly. In the event of an inadequate sample size, recruitment would have continued until the aforementioned range level of participation is met to reach data saturation. Participants had to accept and confirm informed consent electronically before beginning the interview. Each participant showed that they voluntarily participated in the study by emailing to confirm acceptance. Data was collected from interviews conducted via Zoom or Teams platforms depending upon how the participant wanted to conduct the interview, as determined by the participant's preference. The research investigator will conduct all interviews, and data will be collected at the time of the interview via video or voice recording with participant permission and through notetaking.

Participants will also be informed that participation is not compulsory and that they can leave if they become uncomfortable with the research work or with anything

else in this study. If this had occurred, a replacement participant would have been chosen in the same manner as described above.

Each participant was interviewed a single time, during which they were asked the predetermined interview questions listed above with no follow-up interviews. These interview questions were designed to interrogate the leadership and management decisions that were made before, during, and after the merger took place, allowing me to answer the research question. Interviews were conducted through a narrative inquiry approach and were primarily driven by the participants.

Data Analysis Plan

For each type of data collected (audio/video), interviews were transcribed by using Otter.ai then reviewed comparatively to ensure accuracy. Information was categorized according to themes with particular attention to the relevance from the interview questions and the connection of data to specific research responses categorized in the same manner for each subject.

I used the Atlas.ti program for further coding the collected data from the respective research interviews initially. Then, I coded the interview data line by line manually. Atlas.ti software was also used for data analysis in this research study. Because narrative inquiry does not produce discrepant quantitative data, statistical analysis is not applicable for this study. Interviews were analyzed using the narrative inquiry framework as described by D. J. Clandinin et al., (2017).

The study used thematic analysis and Atlas.ti coding to analyze the coded and winnowing – or paired down – data from the interviews and literature to contribute

knowledge to the scholarly literature. The thematic analysis allowed me to produce themes from the analysis of data from the interviews. To start the analysis, I familiarized myself with the interview data. I read and reread the interview transcriptions and noted the important themes throughout the interviews. After emerging themes were identified, a code, according to Sabahelzain et al., (2019) is a word or phrase that is used in research to capture and summarize the essence of a portion of data. In Atlas.ti, the coding process involved gathering related data into a container referred to as a node.

Each research question was numbered, and each participant was assigned a random ID number to correlate the responses to each question. Discrepant cases were not applicable in this research, as each participant had their own experiences to share and there were no wrong answers.

Issues of Trustworthiness

Several areas of potential concern were carefully considered to ensure that the study was trustworthy and that appropriate measures will be taken to limit these issues (Gunawan, 2015). These include credibility, transferability, dependability, and confirmability. Collectively, these factors may influence the study's validity, and it is important to limit these issues to the extent possible and to remain cognizant of how these factors may impact the study (Connelly, 2016). Additionally, ethical concerns were reviewed to ensure that the study was done appropriately concerning human participants' involvement.

Credibility

Credibility measures the true value of qualitative research and whether the study's findings are correct and accurate (Mohajan, 2017). Cope (2014) noted that credibility is integral to descriptive research design. To ensure credibility, I carried out member checks. Member checks involve clarification of responses from participants during the interview sessions and reviewing the themes identified during the data analysis. After completion of the interview sessions, the results were transcribed, and manuscripts were sent to the participants to ascertain the accuracy of the information collected. I also used data triangulation to ensure the study's credibility. Several methods were used to collect data in the study. The study used interviews as its primary data source. However, secondary resources for this research will come from pertinent healthcare merger applications, documents, and proposals available to the public, which may be used to ensure triangulation and verification of facts provided by interviewees. I will utilize data triangulation to ensure credibility and internal validity.

To establish credibility and internal validity, the research observer provided detailed instructions prior to the interview process, provide the participant with the research background data, and a consent form, and request permission to record or videotape the interview session or allow them to video record responses to the interview questions. All participants were provided with the same information and the same options for participation. No incentives were provided to participants for being part of the research study. Complete transparency was maintained to ensure credibility and compliance with IRB protocols. It is worth noting that there is no way to ensure

participants are truthful in their responses. Additionally, I maintained prolonged contact with study participants, participants were provided with interview transcripts to ensure consistency and credibility. This research was able to be inherently transferable as the goal is for the research to encourage the sharing of knowledge and experiences in the healthcare leadership role. However, on the contrary, there were known limitations to the transferability of this study because the research is qualitative in nature and relies on interviews and relatively small sample sizes (see Queirós et al., 2017; Yin, 2015). The research will include interviewees from multiple leadership positions at multiple institutions to increase generalizability. However, due to the voluntary nature of this study, it is assumed that participants will be truthful in their narrative, as the participants in this study are unlikely to have anything to gain from sharing false information. Thus, participants were presumed to be credible, as I was not given reason to believe otherwise.

In terms of addressing the appropriateness of the narrative strategy, this research followed a study conducted by Elliott et al. (2020) in Scotland. They explored the lived experiences of frontline leaders assigned to integrate a single partnership transaction of health and social care services. There was no need for triangulation, prolonged contact, member checks, reflexivity, or saturation.

Transferability

Transferability, according to Rose and Johnson (2020), refers to the ability of a study to be applied in different contexts while at the same time maintaining context-specific research. To ensure that the study maintains transferability, I independently read

and re-read each transcript while noting down areas that could compromise the transferability of the study.

This research was inherently transferable as the goal was to encourage sharing knowledge and experiences in the healthcare leadership role. However, on the contrary, there were known limitations to the transferability of this study because the research was qualitative in nature and relied on interviews and a relatively small sample size (Queirós et al., 2017; Yin, 2015). The research included interviewees from multiple leadership positions at multiple institutions in order to increase transferability.

It is also relevant to note that the research will be delimited to the New England area, which may limit transferability to healthcare mergers in other regions. That said, New England is home to some of the world's preeminent healthcare facilities and hospitals that many other hospitals mimic. Therefore, the research indicated that this study will be generalizable to other hospitals that may be considering mergers, as the participants will be prompted to share the reasons behind the decisions to merge.

Other hospitals with similar issues or problems may find this information useful in making merger decisions. Furthermore, the decision to only consider hospital mergers that have taken place within the last 5 years increased the transferability of findings in the context of the rapidly evolving healthcare landscape. According to Hadi and José Closs (2016), providing a thick description allows the research to be transferable and increases its trustworthiness.

Dependability

Dependability was maintained by following set guidelines for tracking, collecting, recording, transcribing, and analyzing the research data. I documented and reported the data collection process as well as the process of data analysis and narrative construction so that adherence to the prescribed method could be confirmed. Multiple individuals from various positions were interviewed from at least one institution to not bias the data. I listened to the interviews and read the transcript of each interview multiple times, taking descriptive notes and comparing these across instances of review to ensure that the identification of emergent themes is reproducible.

Confirmability

Conformability refers to how neutral and open to bias a study was; throughout the research process, I ensured that potential biases were identified and noted to avoid compromising the quality of the study (Hadi & José Closs, 2016). As previously mentioned, this research was recorded and transcribed verbatim in an audit trail to ensure the research and analysis were conducted from the data provided by the participants and not from my or any biases. I also implemented a reflexive journal to control any influence that could be entered into the research data. Multiple individuals were interviewed at each institution whenever possible so that claims could be cross-referenced across interviews to check for consistency, and facts were checked against internal or external documents to the extent possible. These procedures helped to ensure that the data collection and analysis were not influenced by researcher bias (see Amankwaa, 2016). Interviews were conducted using a narrative inquiry approach, which is highly participant-driven, and all

interview questions (Appendix B) were predetermined to minimize researcher bias in asking leading questions or guiding participants toward a particular topic. Lastly, the participants were emailed a copy of their transcript for member-checking, where participants had the opportunity to correct anything that may have been misrepresented by the transcript (Candela, 2019). Member checking was performed in a timely manner in order to ensure that the interviewee is able to recall the interview accurately.

Ethical Procedures

This study was conducted following ethical research procedures as determined by the Walden University Institutional Review Board (IRB). Appropriate measures were taken to ensure participant data remained anonymous and confidential, including de-identifying participant names and organizations. Organizations were given the pseudonyms O1, O2, …, and O10, and participants were given the pseudonyms L1, L2, …, and L6 to protect the identities of the organizations, all workers at the organizations, and the identities of the participants. Copies of the interviews were held for as long as the IRB requires them to be, after which data was destroyed.

IRB approval was completed prior to conducting any interviews. This research had no ethical concerns, as participation was voluntary, and participants were not compensated. All participants signed an informed consent form before interviews were conducted and permitted interviews to be recorded. Further, participants were informed before the interview that they had the option not to answer any questions they felt uncomfortable with and would otherwise not be coerced into discussing any topics they did not want to discuss. Due to the interviews being conducted using a narrative inquiry

approach, the topics were driven by the participant, which further reduced the likelihood of encountering uncomfortable subject matter that may present an ethical quandary.

Participants were informed of the voluntary nature of the study. Hence, no incentive was offered to the participants. I informed all the participants about the need for current research and how its findings would be beneficial not only to the health sector but also to the general public.

Summary

In summary, this study used a narrative inquiry approach to investigate the lived experiences of healthcare leadership leading up to and after a merger. The primary data collection method was interviews with selected leaders of New England healthcare institutions that had undergone a merger within the last five years. These interviews were analyzed to identify common themes, hoping to gain insight into leadership strategies commensurate with positive merger outcomes. Chapter 4 describes the actual research, data collection, and the coding of the interviews and includes a presentation of the results and findings.

Chapter 4: Findings

The purpose of this qualitative narrative inquiry was to explore the experiences of healthcare leaders related to merger decisions and potential strategies for implementation of leadership in a merger context. The nature of this study was to conduct a qualitative, narrative inquiry approach that explored the lived experiences of hospital leaders who have been part of the formation of new healthcare systems or mergers that have taken place in New England. The plan was to answer the research question "What are the experiences of healthcare administrators (leaders) who have led decisions to merge hospitals or community healthcare organizations?"

In this chapter, I presented information on the investigative process, data collection, interview questions and answers for the study. I discussed the comparative analysis and coding that I completed. I provide an in-depth look at the lived experiences of healthcare leaders relative to healthcare mergers by reviewing the interview responses from the participants of this research study. Research transferability, credibility, limitations, and trustworthiness were discussed. I also shared the respondent data and the analyzed findings. I will explain how the data was collected, coded, and what similarities were found between the respective responses from the research participants for this study.

Research Setting

The research setting was exactly as planned in Chapter 3. All interviews were virtual via Teams or Zoom platforms, which was at the participant's discretion. The interviews were structured and followed the same pattern of questioning for every participant. I was the consistent instrument used for this study. In this study, the

participants were identified in a manner that would protect their identity and mask their organizations, as both the participants and the organizations were assigned random ID numbers and names. There were no personal or organizational conditions to influence the participants or their experiences at the time of the interview that would influence the interpretation of the study results.

Demographics

There were six research subjects participating in this study. There were five male participants and one female participant. All the participants met the study criteria of being in the New England region and being C-Suite Executives during the merger experience. For this research, the titles of the C-Suite leaders were chief executive officer, president, vice president, chief transformation officer, chief operating officer, chief strategy officer, and board of director member/general counsel.

Figure 6

C-Suite Level Organizational Chart

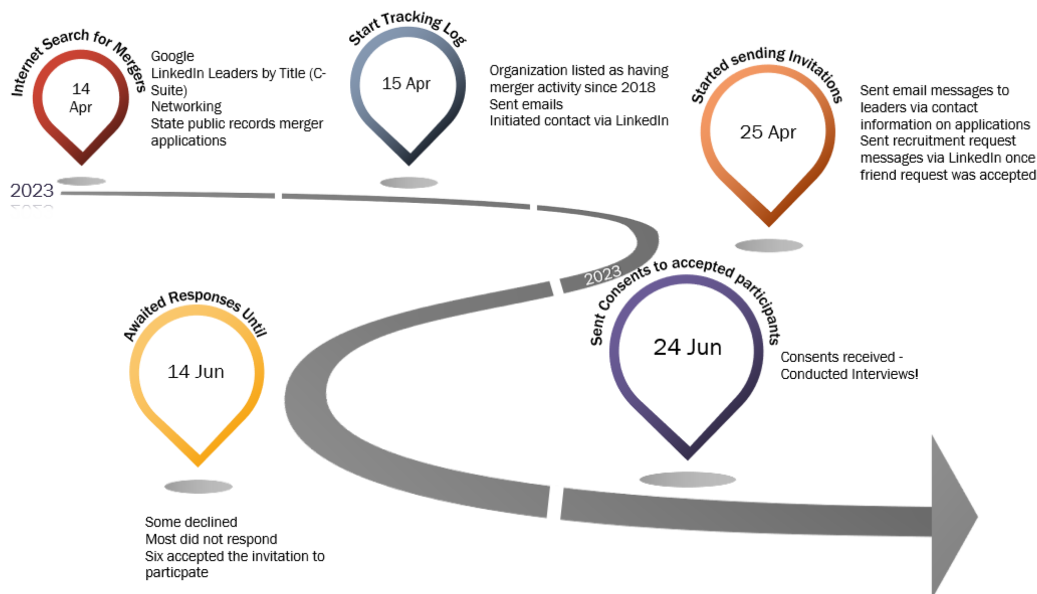
Data Collection

Keeping to the data collection strategy laid out in Chapter 3, the initial step to recruit participants was an electronic letter sent to the participants directly. Participants

were required to confirm their consent to the IRB-approved informed consent form before beginning the interview via email to show that they voluntarily participated in the study. While following the IRB regulations, these six adult participants were purposefully recruited from a large population. I sent over 150 emails and 100 instant messages via LinkedIn to find qualified participants. After careful understanding and research into narrative inquiry research methods, the decision was made to use six participants for this research qualitative study.

Figure 7

Participant Recruitment Process



Data Saturation

Saturation was met when the six participants were recruited for this qualitative research approach. Previous research results showed that across 16 tests using various approaches to saturation, the sample size for saturation ranges between five and 24

interviews (Hennink & Kaiser, 2022). The smallest sample size for saturation was five interviews in a study with a homogenous population intended to support survey findings and where saturation was sought in broad categories (Constantinou et al., 2017). Together, these study characteristics explain reaching saturation at six participants (Hennink & Kaiser, 2022).

Data was collected from interviews conducted via Zoom and Teams video meetings, which were determined to be the participants' preferences. I conducted all interviews and collected data during the interview via video and voice recording with participant permission and transcribed using the Otter.ai program. Participants were informed that participation was not compulsory and that they could opt out if they were uncomfortable with the research work or anything else in the study. If that occurred, a replacement participant would be chosen in the same manner as described above. Each participant was interviewed one at a time, during which they were asked the predetermined interview questions with no follow-up interviews anticipated. These interview questions were designed to probe the leaders and management decision-makers after the merger, allowing me to answer the research questions reflectively. Interviews were conducted through a narrative inquiry approach and, as such, were primarily driven by the participant's experiences. Table 3 shows the list of interview participants with the platform where the interview took place and the length of time the interview was recorded.

Table 3

Participant Interview Platform and Length of Interview

Participant	Interview Platform	Length of Interview
Leader 1	Teams	29:57
Leader 2	Teams	43:09
Leader 3	Zoom	19:56
Leader 4	Teams	20:28
Leader 5	Teams	13:02
Leader 6	Zoom	23:02

The coding process involved a hybrid qualitative methodology approach for thematic and inductive data analysis due to the data-driven research regarding the emergence of codes, concepts, themes, and categories. There were no priori codes. There were deductive indications that stemmed directly from the participant responses. This approach was complimentary to the research questions, allowing the themes to come directly from the participants. I conducted line-by-line coding of all transcripts to begin the first step in the coding process; there were 230 codes. The second step was to find the themes and categorize the common experiences of all the research participants.

Evidence of Trustworthiness

Credibility

There was no deviation from the credibility strategies stated in Chapter 3. I provided detailed instructions to the participants before the interview with the research background data and a consent form, which also requested permission to record the video interview session with the option for them to view the video-recorded responses to the interview questions. All participants were provided with the same information and options for participation. No incentives were provided to participants for being part of the

research study. Complete transparency was maintained to ensure credibility, validity, and compliance with IRB protocols. Additionally, the participants were provided with interview transcripts to ensure consistency and credibility.

This research was inherently transferable as the research aimed to encourage sharing knowledge and experiences in the healthcare leadership role. However, on the contrary, there are known limitations to the transferability of this study because the research was qualitative in nature and relied on interviews with relatively small sample sizes (Queirós et al., 2017; Yin, 2015). The research included interviewees from multiple leadership positions at multiple institutions to increase transferability. However, due to the voluntary nature of this study, I assumed that participants were truthful in their narrative reflections, as the participants in this study were unlikely to have anything to gain from sharing false information.

As previously written in Chapter 3, Cope (2014) noted that credibility is integral to narrative research designs. To ensure credibility, I carried out member checks, which involved clarification of responses from participants during the interview sessions. After completion of the interview sessions, the results were transcribed using the Otter.ai program, then proofread, and manuscripts were sent to each of the participants to ascertain the accuracy of the information collected.

In terms of addressing the appropriateness of the narrative strategy, I partially followed a study conducted by Elliott et al. (2020), which explored the lived experiences of frontline leaders assigned to integrate a single partnership transaction of health and social care services. Supporting that there was no need for triangulation as with this study

and no prolonged contact for this study, member checks were not necessary, reflexivity was part of this study, and saturation was achieved with less than 10 participants.

Transferability

There were no adjustments from the transferability strategies stated in Chapter 3. Notably, the research was to be delimited to the New England area, which may limit transferability to healthcare mergers in other regions. Again, New England is home to some of the world's preeminent healthcare facilities and hospitals that many other hospitals simulate. I indicated that this study would be transferable to other hospitals considering mergers, as the participants would be prompted to share their experiences and some reasons behind the decision to merge.

Other hospitals with similar issues or problems may find this information helpful in making merger decisions. Furthermore, my decision to only consider hospital mergers that have taken place within the past 5 years should increase the transferability of findings in the context of the rapidly evolving healthcare landscape. Providing a thick description allowed the research to be transferable and increased its trustworthiness (Hadi & José Closs, 2016).

Dependability

Dependability was maintained by following the guidelines for tracking, collecting, recording, transcribing, and analyzing the research data, as stated in Chapter 3. I documented and reported the data collection process, data analysis, and narrative construction so that adherence to the prescribed method could be confirmed. Multiple individuals from various positions were interviewed from various institutions so as not to

bias the data. I listened to and read the transcript of each interview multiple times, taking descriptive notes and comparing these across instances of review to ensure that the identification of emergent themes was reproducible.

Confirmability

As mentioned in Chapter 3, I recorded and transcribed the research verbatim an audio trail to ensure the research and analysis are conducted from the data provided by the participants and not from me or any biases. Interviews were conducted using a narrative inquiry approach, which is highly participant-driven, and all interview questions (Appendix B) were predetermined to minimize researcher bias in asking leading questions or guiding participants toward a particular topic. All participants were emailed a copy of their transcript to check for accuracy. Participants had the opportunity to correct anything that may have been erroneous or misinterpreted in the transcript (Candela, 2019). Member checking was performed promptly to ensure that the interviewees could recall the interview accurately. There was no deviation from this plan in the study process.

Study Findings

The interview questions were displayed for understanding and comparativeness to address the research question. The research question is “What are the experiences of healthcare administrators (leaders) who have led decisions to merge hospitals or community healthcare organizations?”

The study findings are presented for each interview question (IQ) with an excerpt from each participating leader's respective correlating transcript response. The first

interview question was asked to inquire about the type of merger in which each participant participated. This process will help to categorize in more detail when the results are evaluated in Chapter 5. There are various merger types in healthcare mergers. There are vertical mergers, horizontal mergers, acquisitions, consolidations, joint ventures, or mega-mergers as defined in Chapter 2.

IQ1: What type of merger was your organization a part of?

Leader 1 created a new corporate entity as the parent company of a nonprofit organization with the intent of creating a healthcare system in which the parent organization had a fair amount of strategic authority to direct where and how care was to be developed and delivered.

Leader 2 shared that their merger was structured as an affiliation between multiple organizations: an acute care hospital, a homecare agency, and a nursing home. It was structured as an affiliation, not a full merger or acquisition. Additionally, Leader 2 was part of another merger that was an affiliation between the two organizations with a parent corporation, and the parent corporation had reserved powers to develop a physician network.

Leader 3 operated as a holding company. Originally, each entity was doing its own thing, making its plans, setting its strategy, and managing its performance, except for setting the margin targets centrally. In 2019, Leader 3's organization pivoted to become an integrated delivery system.

Leader 4 had experience with two major health system mergers. The first one was the merger between two academic hospitals. Leader 4 was more into negotiating and

creating the merger than executing the fallout from the merger. As the head of the clinical program in cardiology, one of the most prominent and critical clinical domains in the merger was to bring those two organizations together. Leader 4 was at the table with other leaders, a small group of leaders within the combined organization, to try to bring them through that process. Leader 4 also sat on the Board of Directors of the institution. Leader 4 again participated from the execution viewpoint and then how to deal with the fallout from it. In that capacity, the more contemporary merger that Leader 4 was involved in really was more in a leadership position and put together the basic framework for the new organization.

Leader 5 worked for an organization with several little companies underneath it. So, all the subsidiaries were acquired in 2021. Another organization acquired Leader 5's organization.

Leader 6 was involved in a full-on asset merger of multiple corporate entities. In the second interview question, I wanted to determine the participant's role and title during, before, or after the healthcare merger. This question was asked because it was also part of the criteria for participation in this research study.

IQ2: What was your role in the healthcare merger?

Leader 1 was the general counsel, and for unusual reasons, the lawyers played far more of a role in negotiating the deal than average, partly because one of the partnering systems' discussions was led by their general counsel. So that meant the general counsel was involved in those, and a tremendous amount of the work that had to be done was not so much between the parties but with the regulatory folks and the Federal Trade

Commission. The hospital leadership took a tremendous amount of effort to get regulatory approval. Leader 1 was involved in both sides of the merger deal.

When the two hospitals became affiliated, Leader 2 had the title of general counsel as the in-house legal counsel, responsible for many of the organization's operations. However, primarily for this merger, the role of general counsel was the biggest piece. Leader 2 was also a member of the executive leadership team and part of the joint affiliation team that included board members, executive leadership, and members of the community who explored the value or not of the affiliation before it happened. Leader 2 was responsible for all the due diligence, including financial due diligence, all the human resources, and everything about the organization.

Leader 3 had a role that was newly created. It is the chief operating officer role which was created specifically to oversee and set all the strategy and decision-making around integrating clinical services.

Leader 4 was the chief network/chief system development and strategy officer.

Leader 5 is a vice president-level individual within the organization and was invited by the chief executive officer to listen to the sales pitches about the acquisition. The chief financial officer and vice president were primarily the ones responsible for pulling together the documents necessary for the acquisition.

Leader 6 was one of the two chief executive officers who led the legacy entities into combining.

The third interview question was asked to understand the surrounding environment that the leader had to deal with and to determine if they had any assistance or guidance afforded to them during this endeavor.

IQ3: What guidance were you provided to assist in the merger?

Leader 1 was part of a small group of executives who were involved in the decision making but ultimately the chief executive officer made the final decision, which I think was very informative to have a small number of people involved in this process and to have everybody also continue doing their day jobs as if the merger was not going on. Also, everybody was focused on delivering care and making sure that the finances were in shape and doing the things needed to survive and thrive. People that made a lot of the decisions around each element, whether it is governance, finance, legal, all those things were involved.

Leader 2 did not feel there was much guidance provided regarding the merger process. Shared it was easier because it was two nonprofits coming together. But everything about the process was new. And since no other hospitals had gotten through this conversion process with the state, they did not have a lot of people in the community to go to ask how they did their filing in the past and what worked because nothing worked historically. They did have outside financial auditors who helped review all of the financials and helped with the financial due diligence. They had some outside legal help. But not much, just to ask questions if there was ambiguity in the statute or any of the filings or things of that nature. They just figured it out themselves.

Leader 3 did receive guidance from the Board of Directors and from the Chief Executive Officer to complete the merger and accomplish the integration as quickly as possible and on multiple fronts. In other words, did not just focus on one thing at a time, but really tried to do multiple things at a time. That was the advice they got from above, the advice they got from below or guidance they got from below was that they have two fantastic academic medical centers (AMC) that are both amazing. They both have phenomenal research programs. They both have outstanding faculty; not to disempower them or hit them so hard with change. The guidance from below was to preserve and build on what has made the system great to date. Also, not to tear down or damage progress that has already been made inadvertently.

Leader 4 had notions of where they wanted to go and what we were trying to achieve. They hired outside consultants who guided both organizations. There was guidance provided by an internal constituency (mainly the board) and guidance provided by an external constituency (a very effective consulting group) that had worked with them for a long time and was engaged to work with both parties. There was a common vision being developed from the beginning stage, which was an amazingly effective way of creating a merger that did not have the turmoil and the infighting that had been observed in a previous merger.

Leader 5 was directed by the other organization that was involved with the acquisition. They would have their attorneys and their accountants sort of poised to extract all the information that they needed from this leader. Everything that was prepared was at the request of somebody from the buying party's side. They would say

we need a, b, c, d, and e, and those listed documents would be prepared and then delivered to them in a drop box where the leaders on the buying side would put all their pieces in place and ask more questions.

Leader 6 had guidance at multiple levels from their team which included the chief strategy officer, chief financial officer, and other members of the senior team with oversight by the board of directors specifically a subset of the board tasked with overseeing the merger through to completion and providing guidance to external consultants.

The fourth interview question was asked to learn more about the participant's knowledge base and experiences before the merger which is helpful information when comparing the experiences and actions of each of the participants.

IQ4: What was your professional background experience from the decision to merge through completion?

Leader 1 did not have the background of most healthcare general counsels. A large majority of general counsels in hospitals came straight out of healthcare backgrounds. They may have been in-house counsel for a long time. Often, they would have a lot of merger and acquisition experience, they have a lot of fraud and abuse, a lot of billing, a lot of healthcare, and traditional healthcare experience. Leader 1 had a very modest amount of experience compared to most and was involved in a small number of smaller mergers where the legal background was completely different from healthcare. Leader 1 was a litigator for many years, a regulator, formerly worked in the Attorney

General's office, and was in a small law firm as a lead but was never a straight healthcare lawyer until this organization.

Leader 2 had a legal background which helped to let them know what was going on operationally and some pieces of the hospital portion but all those requirements with the filings and negotiating and drafting of legal documents that were part of doing due diligence; would not have been known. Leader 2 did not know how to do some things but did know how to draft documents and knew how to ask questions, and how to read statutes and draft applications based upon regulations. But that was simply basic legal 101 stuff. Knowing the operations of the hospital was huge. Leader 2 had professional experience with the operations of the hospital which was incredibly important. The legal background came in as an added value to the process.

Leader 3 was the first chair of a new department of emergency medicine in a major academic medical center in Canada, for six years. Then, was the first chair of a new academic department of emergency medicine in an organization here in the United States specifically in the New England region. So, both times came into jobs that had not existed before. Having served in that role for 20 years was critical preparation in two ways; first. it gave a trailblazing spirit to start something from nothing because in both cases, there was no department infrastructure, and second, being in emergency medicine is two core experiences of skills. The first core experience is the ability to manage multiple complex situations at the same time, whether it is clinical or administrative. The second core experience is having to work collaboratively with every single department in the hospital. Both of those core experiences prepared Leader 3 for the merger leadership

role. But it also carries those other two things of having to deal with multiple tasks that are often complex and prioritize them properly. Emergency medicine leaders also collaborate with multiple different stakeholders across the system consistently.

Leader 4 was a physician, trained as a cardiologist who was now in a leadership role that was in an academic, clinical career path teaching some research, but mainly political career path within the organization. During this time began to assume some clinical leadership roles and institutional leadership responsibilities. After the big merger was formed, assumed the role of a senior principal position. This allowed growing knowledge, and skills, over many years working with others and the experience to lead in a merger. Then, found a way to be educated by peers that brought additional skills to the table, which was extremely helpful to having somebody with a strong clinical background. But, in terms of the legal aspects and financial aspects or other elements of this process, it was learned by sitting at the table. A robust skill set in terms of some of the issues needed had been developed. Leader 4 helped lead those efforts with the chief executive officer (CEO), leadership team members, legal counsel, chief financial officer, etc.

Leader 5 was tasked to bring new service locations online as vice president and would work with lease attorneys, architects, and working with clinical staff to produce the ideal sort of configuration layout for the new clinic space that was to be opened. Leader 5 worked with the licensing authorities on getting the programs licensed and then working internally with the finance team to make sure that the financial resources could pay for the build-up and worked on the operations. Also, made sure that all staff were

lined up, hired, trained, and ready to go on day one. Worked with the regulators, just making sure that everything was buttoned up tightly so that it was a licensed site. Leader 5 had an acumen for leasing, budgets, and expense histories.

Leader 6 had been a chief executive officer for 12 years and was involved in multiple acquisitions of smaller health centers over 12 years. Before that, was in several other healthcare systems integrations and even prior to that was involved in the corporate world in non-healthcare acquisitions but originally trained as a physician.

The fifth interview question was asked to gain experience detailed reflection and asked about what lesson each participant may have learned from the merger process with hopes that they would have more information to share with this open-ended questioning. This was the time that many shared some regrets.

IQ5: What are some lessons learned from the merger process?

Leader 1 learned to decide upfront roles and responsibilities within their team. And try to control the number of people, if at all possible, who really can add value to the merger process, not involve more people than needed because other people will need to continue to work the day-to-day operations. There has to be a sense of urgency about the work, but there has to be a sense of patience working on the day-to-day things because things are not going to happen the way they are planned to happen. Understand that the merger process is like a roller coaster. At the end of the day, be prepared for many different challenges to threaten the plan and to throw the process off target. Maintain some equanimity and figure out which tasks are worth fighting about. There are going to be personality conflicts; there are going to be power struggles; and some of which are to

be expected. It took three or four previous attempts to merge in part because there were insuperable objects and insuperable issues. Try to get issues resolved as early as possible to not want to waste a year and a half or two years just to find out that nobody can agree on who is going to be the chair of the board of directors or the future chief executive officer.

Leader 2 learned to be ready for the long haul. It is a tedious, tremendous amount of work and the level of detailed work that needed to be done in the pre-merger stages prompted questions like: "What are we going to do?" "Can we make it on our own?" "Can we not make it on our own?" That is the first lesson. Another lesson learned was that no matter how long it takes and no matter how painful it is keep going. A huge lesson learned is to take as much time as you think you need to do a robust job of due diligence. Also, from a leadership perspective, but also a board member perspective is important to be realistic about what the future state is going to look like for the organization.

Leader 3 learned that people are the most important part of the business in the merger process. Managing people and helping them navigate change is so important. This is particularly true for high achievers. People who are enormously proud of where they are in their careers and where their department is where their hospital is and are being led through a change. It is really important to understand the why of the change and to get help understanding some of the sense of loss in the autonomy of grieving through some things that staff may feel that they once had, that they will not have anymore. If you go too slowly, you will impair the progress of your organization toward its new future. And

if you go too quickly, you risk leaving people behind, and not bringing them along through the change. So, leaders cannot afford to go too quickly or too slowly, figuring out what is too quick and what is too slow is the hard part.

Leader 4 shared that there are a lot of lessons to be learned. The biggest lesson to come away with is that leaders cannot underestimate the value of planning, being respectful, and understanding the position of others, especially the people that leadership is trying to bring together. The need to compromise and the importance of culture should not be overlooked. If there are cultures that are simply diametrically opposite, things are not going to work. The importance of all these lessons became obvious when planning the creation of this system.

Leader 5 had gone through mergers three times before and thinks the thing that was learned is that when the next request for something like this comes along, there will be a better sense of understanding of what is expected in the merger process. Meaning leaders become engrossed and focused on doing everything necessary to arrive at the close of the deal. While focused on this, the work of the company, the clinical care continues for the patients that need treatment. The executive leadership's work becomes completely focused on getting ready for the acquisition. It is high pressure because there are a lot of deadlines to get information together and it is incredibly stressful.

Leader 6 shared a couple of lessons learned. The first was that things take time and patience. This was not a merger that happened over a weekend, there were two failed attempts at this exact merger, before actually coming to fruition so patience and time were essential. Everybody needed to take a deep breath and keep at it. The right external

environment needed to occur for the merger to ultimately be successful. The next lesson learned was to plan for many things, but also recognizing and acknowledging that there may be no idea of things are coming down the path. The best example that can be discussed is the fact that one year to the day after the merger, a worldwide pandemic happened, and no one could have planned for that.

The sixth question allowed the research participants to share absolutely anything that they wanted to share with me regarding the merger experience or the merger process. The goal was to collect as much experiential knowledge as possible.

IQ6: Can you share your perspective of the merger process?

Leader 1 shared that a merger is very much a process. Once the strategic vision for what the merger would look like and how it would operate and what the goals of the merged entity would be structured. The leadership addressed a lot of moving parts of the organization. They reached out to one another, so that there were the beginnings of a shared culture, the beginnings of a shared vision, beginnings of letting people know about the intentions for the future of the organization. Continue trying to keep the organization as a great place to work and actually grow it and give it opportunities to do a whole lot of new and different things.

Leader 2 shared that a merger is an extraordinarily long process (regulatory-wise), and that all states are different, but their state was probably the most restrictive when it comes to health care affiliations and mergers. Leader 2 thinks it is more restrictive than it needs to be and more administratively burdensome. These entities are huge community assets that the state has a big interest in protecting, particularly as a nonprofit. One of the

things a leader really needs to look out for in this process is to make sure not to have a separate agenda, whether it is consciously or subconsciously. Checking yourself as leader throughout that process to make sure that you are doing what your obligation is, which should be putting the institution first. This is a chaotic and extremely expensive process.

Leader 3 can add lots of different perspectives but would share the primary perspective that the single most important thing leaders are going to do as an organization in the last 10 years or the next 10 years is to be driven by the patients and the patient's needs.

Leader 4 thinks that careful planning, ideally before the merger is actually executed and understand that there are also limits to what you can do in this process. There are legal limits and requirements to meet. The regulatory process takes a very long time which gave them a chance to collect more information on the other entities, even after we had decided we wanted to do it. Use that time very effectively, to bring key elements of the organization out to the other organizations and begin to develop a shared vision and planning.

Leader 5 shared that the acquisition itself took three to four months of intense preparation activities. All the other stuff sort of slows down. The regular work of the company continues to make sure that care is being delivered, but the C-Suite executives all shift entirely to preparing for the deal to conclude.

Leader 6 thinks that like many mergers, there are multiple factors in understanding how mergers move forward, and why some come into fruition and some do not. Even speaking about whether they are ultimately determined to be successful, will

be evaluated in 10 or 20 years. But some of it, for better or for worse, has to do with the personalities involved. Because the principals involved either can figure out how to make compromises or cannot figure that out. This was a little disappointing for this leader to share.

The seventh and eighth questions were asked to see if the participants would provide any expertise, professional attributes or requirements for leaders that would make the merger experience more positive or successful. This knowledge would definitely be helpful when providing recommendations in Chapter 5.

IQ7: What knowledge or expertise should a leader have prior to embarking on a merger?

Leader 1 believes a leader has to have a team that he or she relies on. The leader cannot do everything for him or herself and cannot micromanage. There are just too many moving parts. Trust the people around them. Be prepared for obstacles or challenges and be prepared to make decisions sometimes without full understanding and knowledge of what has transpired. Be prepared to make some strategic decisions as to which directions things need to go into and to be open to some adjustments along the way. It is going to be a long and difficult slog.

Leader 2 thinks that a leader should have consistent expertise in strategic planning, knowing how to do a strategic plan, knowing how to get into the details of a strategic plan, because you never going to figure out whether that partner is going to be able to effectuate the clear vision and goals that need to be set out at the very beginning of the process. Also, financial acumen is important as an expertise for a leader; knowing

how to read a spreadsheet and a balance sheet and putting together a proposal for efficiencies that will work on what those numbers mean. They must know how to make a robust pro forma. Negotiating expertise is particularly important. These agreements are highly negotiated and tricky. As a leader, if you are not a lawyer with negotiating expertise, have some expertise in that on your leadership team and know when you are over your head then get the help that you need from your resource team.

Leader 3 thinks they must have useful content knowledge of the organizations they bring together. It is the things you do not know about or do not know enough about that are most likely to create major problems as you go along. So having relevant content knowledge of all organizations being merged. The second is determination and consistency. The ability to assimilate many complex inputs, and create simplicity around them, is essential to both creating the vision in the first place and second to solving problems as you execute. So that ability to simplify complex structures and matrix organizations and so on. Being empathetic to the needs of people and the ability to make others understand that the leader that is guiding them through all this change also cares about them and understands what they are going through is important.

Leader 4 thinks any good leader, in terms of a merger, must have appropriate financial, legal, organizational, and operational knowledge. They do not have to be experts in each of these ways, but the combined leadership must have all that knowledge and skill. Also, understanding the regulatory environment is critical. The leader must have a clear vision of where they think the organization should be going and be able to articulate and communicate that message. Each element of a merger, each constituency

needs to be brought along, and needs to be prepared for what is ahead of them to the greatest degree possible. The same guidance applies and the same skill sets are necessary in terms of how a leader views things and how a leader begins to execute.

Leader 5 does not think it is always possible to know what is specifically going to be expected when one goes through it unless you have done it before. It takes much organization of the information you are being asked to prepare. Organizational skills are critical to ensure you are providing everything requested. Be prepared to answer all the questions the future owners will have for them.

Leader 6 thinks there are a variety of things a leader needs to understand about their own organization. A good understanding of realistically where the organization stands and where it needs to be and what that gap is. The leader needs to have made some attempts at bridging that gap and understanding that more needs to be done if you are going to think about doing a merger. Ideally, a leader will have experience in doing this already, having been involved in mergers and having experienced multiple cultures at different organizations that are coming together needs to have a temperament that allows you to compromise. Keep eyes on the ball to know that each of the setbacks that inevitably occur in the process is for the course, in the scheme of things, then in three- or five- or 10-years' time the setbacks are pretty negligible compared to the decision itself to move forward. Lay out those reasons and find a way to make it happen.

IQ8: What suggestions would you recommend to future leaders embarking upon a merger?

Leader 1 suggests having a noticeably clear understanding of what each party brings to the table. And why it is important that they come together. Have a very compelling vision of what could be done. But, both for internal and external expectations, you must have a clear and strong understanding of what value the merger will bring internally and externally. Also, be clear that the path towards seeing that value is not a straight easy one. Putting the merger in place or getting to an effective legal merger is only step one, the integration process can be just as hard and demanding because it requires a different kind of attention and effort on the part of leadership.

Leader 2 thinks it is important to know what the reasons and benefits are, what goals are you solving for. Vetting your options is huge, like doing a serious deep dive vetting of them. Due diligence is really a huge thing. But really, the most important thing about embarking on a merger before you are really going to send out that request for proposal (RFP) is to get buy-in from all those constituents. Make those rounds. Must have 1,000,002 meetings and describe what the issue is and why this is happening organizationally.

Leader 3 believes in a deep personal understanding of why this is happening. The leader must have no doubt or lack of understanding in what their purpose is and what they are trying to achieve. Because the tendency is when the resistance to change gets overwhelming, to flinch or to change course. This is the time that they cannot afford to flinch.

Leader 4 recommends understanding the business and strategic rationale. Not all mergers are good. There is sometimes a tendency to decide to merge for the sake of merging usually with the assumption that more scale will be good. The bigger is not always the better. But even if there is a rationale to that argument, there are so many things that could allow it to be successful or not, just be cognizant of all of these things. There has to be a clear strategic rationale. And there has to be a clear vision by how these organizations can function together, how governance will be created, how leadership and management is organized, what vision future taking advantage of new organization in the market is going to be what opportunities arise by whatever and scale you get, and how do you ensure that that occurs, because that means change for people. The leadership needs to be able to articulate that.

Leader 5 suggested that whenever there is a merger or an acquisition everyone wants to make sure that you are doing it in the best interest of all parties. Therefore, paying attention to the industry and the marketplace and who the key leaders are and who the potential acquirers are, is really important.

Leader 6 believed it is easy to get lost in the myriad of details and in the fights or arguments regarding 1000 different things that are included in the contract. It is more important to be able to take a step back and ask whether this is something that anybody is going to remember in five- or 10-years' time. But it is really important to understand their motives and not to cast aspersions on other organization's vote. Find a way to come together.

I wanted to know if the participants believe they could have learned the skills that they needed to conduct and devise the merger plan or process by thinking retrospectively.

IQ9: Would you have found value in training to prepare for mergers as a leader?

Leader 1 was unsure whether training would have prepared the team for the merger so that there would be any value in it at that time.

Leader 2 stated that they were kind of flying blind the first time. There are regulatory heavy lifts and the hurdles were many. But there are consistent things that states are looking for and would have appreciated training in what the Federal Trade Commission (FTC) looks for from an organization wanting to merge. It would have been helpful to have some training with the federal application. A checklist for due diligence relative specifically to the healthcare industry would have been helpful to have some training on exactly what to look for how broad to go, how deep to go with preparations and documentation.

Leader 3 initially did not think training would have been much value but would have found value in planning assistance. Having the right people together to think through how to plan the merger with knowledge. Eventually Leader 3 guessed that training in a way could be beneficial. But not sure if a leader could be trained for the merger process. But the need to bring in people who are change management experts and communications experts to work with leaders as full partners all the way through would be helpful. Leader 3 guesses it is training but would think it is more dynamic training or just-in-time training as you work together through these different areas of the merger.

Leader 4 did not know what kind of training could even be talked about because no merger is identical. Everything has its own specific things. It is not so much training as making sure that you have the necessary competencies within your management team, which again, are obviously financial, obviously, strategic, and business development, obviously, legal, and regulatory, and a clearly articulated, and clinical leadership, if it is a healthcare merger, clearly articulate the rationale. As Leader 4 reflected a little bit more, one of the most important things that was found helpful is very early on having a combined agreed strategic and business rationale.

Leader 5 stated that there is a first time for everything. If one has not done this before, it is definitely a learning curve. But once experienced, the knowledge is obtained. And when leaders understand the scope of what has to be done, in order to make a deal occur, they have an idea for how long the process can possibly take, what kinds of questions pop out, and all of that experience is really what helps train leaders for doing the next one. So obviously, the more one does these things, the more seasoned they are in it but there always has to be a first time.

Leader 6 thinks having the experience is the training that you need to have. And so having actually done this, or done this multiple times, in different environments with different cultures, that's the training.

The last interview question was asked to inquire into whether the participants would have liked to have known anything in advance about mergers or the process if that was possible.

IQ10: And what would you have preferred to know in preparation for such an endeavor?

Leader 1 did not think there was anything to wish to have known in advance. Different mergers have different tempos and they have different challenges. In this case, as hard as the bringing of parties together was the regulatory lift and the integration lift was large. Leader 1 would have valued somebody sitting down and saying these are the pieces of what you are going to go through in the next five or six years. Or, just here is the terrain you are going to have to battle and here are the challenges, the kinds of challenges, getting the parties together will be these kinds of challenges, regulatory challenges, integration challenges.

Leader 2 would have liked to know more about the regulatory aspects in the merger process because the Department Public of Health (DPH) and Attorney General's Office (AG) did not know what to do either. So that made it harder for them because it was overwhelming for everybody.

Leader 3 would have preferred to know that everyone in senior leadership roles in the organization had a very clear understanding of exactly what their roles and responsibilities would be in the new world post-merger. Everybody knew what their role and responsibilities were in the old world. If we do not create role clarity, for everyone going forward and those things and that being negotiated and renegotiated. It is better to know in advance what the domain responsibilities are of each of the senior leaders and the short days, as well.

Leader 4 thinks in any merger, both parties do a fair amount of duty diligence to understand the financial state risks, business risks, legal risks, but none of that really tells you cultural issues.

Leader 5 stated to really understand the process one has to learn all the mechanics around how mergers work. Learning it in books does not really train for what the experience is like without going through it.

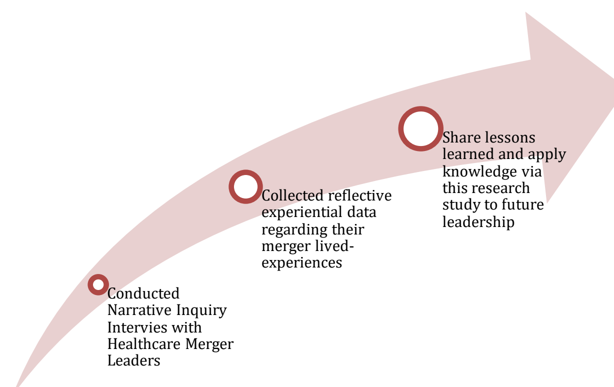
Leader 6 would have preferred to have known the future about the pandemic. None of us have a crystal ball. It is important to create an organization that is maximally flexible to adapt to changes that you do not know about upfront.

The interview consensus was that mergers are challenging, take time, and require patience and teamwork. There is a lot to know and learn. Many could have found more experience useful, and some training or knowledge about the endeavor in advance would have benefited their experience. Many believe leaders must wear many hats and be prepared to change direction at any point during the merger process. Each of the interview questions helped the study with regard to understanding the reflective experiences and perspectives of these healthcare professionals.

Keeping true to the observational learning theory, the path leads to now applying what we have learned about the merger experience from these healthcare leaders to the masses since the interviews have been completed and transcribed so that we may now learn from the shared experiences and apply this knowledge to the body of works in this field. Kolb believed learning is possible through reflective experiences, and this study is going to model Kolb’s observational experiential learning theory roadmap.

Figure 8

Applied Observational Experiential Learning



Data Analysis

The six interviewed participants shared their personal and professional experiences reflectively from past merger leadership actions. The source of the data was collected from interview sessions, my interpretation of the audio transcripts, and email communication with participants after sharing the transcripts with them for feedback and approval. After each interview, the responses were transcribed and reviewed for correctness with the participants. The data was analyzed for categories, themes, and codes that could be cross-referenced between participants. This process was repeated for each participant and each interview question until there were no more codes or themes to document.

Five themes were identified from the coding analysis conducted line-by-line in Microsoft Word and by uploading the interview transcripts into Atlas.ti after being transcribed in Otter.ai. The top five themes were: *Leadership*, *challenges*, *merger guidance*, *strategic planning,* and *communication*. Table 4 represents the list of combined

themes that have been identified by the number of participants that shared the importance of each theme.

Table 4

Themes Found in This Study

Themes	Leaders
Strategic planning	1,2,3,4,5,6
Challenges	1,2,3,4,5
Communication	1,2,5,6
Merger guidance	1,3,4,5
Leadership	1,3,6

Theme 1: Strategic Planning

Our participants shared the importance of setting clear and concise goals, vision, mission, and objectives for the merger. They cautioned that the future governance has to be sorted out before the merger is undertaken. If this is not set in advance, there will be strife and power struggles in the future that would harm the merger's success. As far as forward-thinking goes, all but one mentioned the importance of continuing operations during the merger process and having a strong strategic plan is paramount for the merger.

Know what you want the merger to do for all organizations involved. Have a full agreement with combined services and resources, and be mindful of the conflicting cultures and what direction the culture should go in the future. In the pre-merger work, think 5-10-15-20 years downstream in multiple parts: clinical-driven, finance-driven, human-resource-driven, patient-driven, etc. The leader should determine the future or

combined departments, recognize commonalities, and unlock true potential. Put the institutional goals ahead of personal goals.

In strategic planning, the leader should also know organizational limits, legal limits, financial limitations, strategic rationale, and clearly understand their responsibilities, and be able to adapt if necessary after conducting due diligence.

Theme 2: Challenges

The reflection of every participant conveys that there will be challenges when preparing or going through the merger process because mergers have very different tempos and inherent challenges. The leading challenge is the administrative burdens, legal obligations, regulatory hurdles, internal constituency, financial lifts, and many unknown obstacles that may threaten the deal. There will be times when the process will get out of control. That is when the leader needs the trouble-shooting ability to get help when overwhelmed and have subject matter experts on their team. Mergers to these participants are a tremendous amount of work, complicated, highly pressured, and stressful for leaders. Three leaders stated that setbacks are inevitable, leaders should be cognizant that anything can happen at any time, and be clear in understanding that the road will not be easy.

Theme 3: Communication

Almost all participants shared that communication is an important part of the merger process from the beginning to the end. The leader must clearly state the reason for the merger to all constituents: the board of directors, executives, providers, nurses, staff, the community, and patients. Clear articulation needs to happen at meetings,

presentations, town hall meetings, and community outreach meetings to describe issues or the why organizationally. Leaders must be transparent with end users and external stakeholders, keeping all parties abreast of the intentions and transitions. The bottom line is that the leader has to be a strong and good communicator.

Theme 4: Merger Guidance

Only one leader shared that having already gone through several mergers. There was comfort in the amount of guidance provided prior to and during the merger experience. The other leaders believed they could have benefited from more guidance or experience. However, all participants used outside resources to assist them with the merger process. All hired external legal experts. All hired consultants to help them with the merger terrain, data collection, filing, regulatory, or the particulars of acquisitions. Some also hired auditors to help with the fiscal responsibilities for their mergers.

Theme 5: Leadership

There are many skills that each of these participants stated a leader should have. However, the top talent they recommend is to be prepared to make decisions even when complete understanding is not possible. This situation necessitates being flexible and amassing the ability to pivot at any point of the merger journey. They also believe the leader should be patient, have a trailblazing spirit, conduct due diligence, and be able to compromise yet be unyielding at times. The key is to know inherently when to execute these necessary skills at the proper times.

As a leader embarking upon healthcare mergers, negotiation experience was essential to manage complex relationships while understanding the organizational

dynamics. Negotiating the vision, goals, and expectations will set the tone for mitigating differences and competing needs or wants for all organizations involved in the merger deal.

The leader's ability to manage time is also important as they must move quickly and efficiently, most times with an understanding of legal, business, and financial risks. The leader is expected to have relevant content knowledge of all organizations involved and maintain equanimity. This means the leader has to have or gain the confidence of the team and staff that he or she is leading.

Summary and Transition

Chapter 4 stated the purpose and problem statement in the introduction as well as the nature of this research study. The participants shared their learned experiences about healthcare merger deals in this chapter. I discussed the demographics regarding the six research participants and how the data was collected for this study. The evidence of trustworthiness section was reviewed to validity and ethical inclinations of credibility, transferability, dependability, and provided no reason for any participant to be untruthful in their reflections.

The findings discussed in this chapter are representative of the interview response data from this narrative inquiry and how the responses have determined themes and values for understanding of the lived experiences of these healthcare leaders. There was only one research question and that was *RQ: What are the experiences of healthcare administrators (leaders) who have led decisions to merge hospitals or community*

healthcare organizations? The experiences have been collected and reviewed at this point. The findings have been coded and categorized for similarities.

There were ten interview questions in this research study. Each question was displayed with excerpts from each participant. These responses were so profound and enlightening. Although most mergers have been noted as having differences and that none of them are exactly the same. Similarities and differences were found on both ends.

The findings responded to the purpose of this study, which was to learn and understand what experiences healthcare leaders have gone through leading up to and during the merger process. In the next chapter, the findings will be pulled together to formulate implications, recommendations, and lastly the conclusion that have been derived from this raw data and reflections.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative narrative inquiry was to explore the lived experiences of healthcare leaders related to merger decisions and potential understanding of strategies for implementation by leadership in the merger context. This study was conducted to add to the body of knowledge by following the theories of Kolb, Bandura, and Johnson by collecting experiences from these leaders that went through the merger process. Key findings from the interviews conducted supported the need to understand and learn what these leaders had to know and experience before, during, and after the mergers they were leading. Using OEL theory helped me with planning the exploration of the merger decision making process and ultimately how these mergers evolve via leader experiences.

OEL consists of four phases that collectively form a feedback loop to apprise future learning and development (Johnson, 2020). These include concrete experiences, reflective observations, abstract conceptualizations, and active experimentation. The interactions between these stages result in discrete types of knowledge. Kolb (1984) argued that for effective learning to occur, the learner must go through the cycle in its entirety which is what I did in this study. OEL theory was significant in this holistic model of learning and growth that is not linear, but rather follows a cyclical rationale whereby previous experiences influence future directions (Kolb, 1984).

This study, I used a qualitative, narrative inquiry approach to explore the lived experiences of hospital leaders who have been part of the formation of new healthcare systems or mergers that have taken place in Massachusetts. Narrative inquiry is a vital

avenue to understanding experiences, according to D. J. Clandinin and Connelly (2000) and J. Clandinin (2007) because I can learn from the participant in a reflective and recollective manner from the source of the knowledge.

The intent of this study was to understand the leadership perspective which has not been researched much to date in the New England region. Using t OEL theory, I sought to identify new behaviors through the observations of other leaders that have experienced merger decision making. Mergers continue to be a chosen approach by many healthcare leaders, as evidenced by the number of mergers remaining largely steady or growing in complexity (King, 2021). This suggests that these impacts may vary from merger to merger, which even further highlights the need for research in this area.

Interpretation of Findings

The findings from this study will extend the knowledge that was discussed in Chapter 2. The literature review found no significant knowledge about the leadership perspective in hospital mergers. Even now, this is still an uncharted area of study. Although mergers have been sufficiently researched, the leadership experience has not been explored much to date. I found uncertainty in merger outcome research and the trends leading to more complex merger types. This complexity demonstrates the importance of the leadership role in planning and strategically having the vision for such endeavors. The findings from my study were that the leadership role is key to what takes place prior to the merger, during the merger, and after the merger is completed. Every action is planned by the organization leadership from the beginning of the merger to its conclusion. These leaders come together to discuss the strategy that will be used to

address the needs and reasoning for the merger. They conduct due diligence to address all areas of concern and maintain business operations simultaneously. The research each other to be informed on all aspects of each organization that they are considering merging with, such as their finances, legal research is conducted as well, regulatory documentation has to be submitted to the Federation Trade Commission in the state that the merger deal is going to be transacted. The attorney general's office also must be consulted in order for a merger to be approved to take place. These leaders need to map out plans for short- and long-term goals including what the future state and governance the organization will hold at the end of the merger. There are usually several chief executive officers that will have to learn to no longer be in charge once the merger is concluded. This was noted as a challenge by 50% of the participants. Throughout this process, the leaders all must make sure that their board of directors, staff, and community are informed about the intent to merge and keep them abreast of any updates as time goes on. All the participants were in agreement that the merger process is in fact a process that is quite challenging and time consuming. All but one of the participants thought some form of guidance or assistance is needed to help those that have not gone through more than one merger previously.

Limitations of the Study

In Chapter 1, I stated that participant population may have concerns about confidentiality and not want to participate in the study, especially if outcomes were poor. This was not the case for the most part in this study as the participants focused their response on their personal experiences and did not divulge any sensitive information

about the organizations that they work for during the interviews. I also included that the participant responses and the ability to recall information in detail not being sufficient for the study which again was not an area for concern or limitation because all participants had full recollection of every detail of their merger experiences. It was stated that participant bias for mergers could also be a limitation based upon their high-level position within the organization; but it was not a factor in the responses or actions of the participants.

Additionally, as stated in Chapter 1, I had no reason to believe that interviewees would be intentionally deceptive, as there was no incentive to present false information. Participants stand to benefit from being truthful in their contributions to the study (Hudson et al., 2020). These statements are exactly as stated and hold true currently. I believe that every participant was trustworthy and provided honest answers to every question that they were asked.

This research was limited to a specific region in the northeast of the United States called New England that covered six states out of 52. This was the only geographic limitation for this study.

Recommendations for Professional Practice

Based upon the research findings, the consensus from the literature was that the problem is current, relevant, and significant to study. Results were found from the information provided by the following leader responses to the interview questions. Conflicting merger outcomes and lack of leadership perspective research requires more studies into this body of knowledge. The research interviews with this select group of

healthcare merger leaders amassed some prominent recommendations for future leaders and researchers.

The first recommendation is to know the principles of the merger terrain. There is so much to know about in advance and understanding the particulars can make the difference between a successful merger and one with less-than-ideal outcomes. The second is that the leaders must know about the integration process and the demands that will ensue from the stakeholders, the community, and the board of directors. Leadership needs to know how to bring diverse groups together and build strong organizational teams. The details that are necessary for planning the integration are where this skill would shine during the merger.

The third recommendation is that for any merger leaders need to be prepared by having the internal and external experts on hand for all possible issues and in every facet of the merger process. Three leaders shared the fact that no one knows everything, and every leader should have subject matter experts on their team regardless of going through the merger process or getting through business operations daily. The fourth recommendation is to clearly understand what value or needs each organization will bring to the merger deal. This is when all the participants stress the importance of knowing who you are doing business with and getting all their historical business, legal, and financial data. Future leaders should request and review at least 5 years of historical information on each merger partnering organization. Knowing the reasons behind the merger and whether the organizations will meld well is key.

The fifth recommendation is the understanding that organizational culture is a huge part of the merger process, and one must start by knowing what the desired culture should be in the end. It needs to be decided whether the current culture of an organization will remain or if there is a more beneficial culture for all merging organizations to adopt post merger. There are going to be differences that will need to be acclimated to or improved upon as the organizations move forward together. Organizational alignment needs to be the goal for all involved in the merger deal. The sixth recommendation is for leaders to think long term in the planning and understand that sometimes a merger can take 20 years to complete or to see outcomes. When conducting the discovery process, leaders should plan out in 5-year, then 10-year, then 15-year, and 20-year projection increments. The final recommendation is to make sure that the future governance is discussed, agreed upon, and finalized prior to the merger taking place. This sets the tone for the leadership and authoritative nuances that will have to take place moving forward. That leader will need to know the motives of each organization and conduct due diligence regarding the vision, mission, market share, and the industry. These recommendations come from the research participants directly and are held in high regard for what they had to experience and what they believe to be highly important for any merger process and wanted to share this knowledge with other leaders that find themselves at the point of deciding to undertake the merger process.

Recommendations for Future Research

Having only conducted this research in a small and specific location, further research should take place in other geographic areas. This qualitative narrative inquiry

research study was conducted with a small sample of participants, exploration with a larger sample of participants could also be conducted. Other researchers could adopt this study and extend the research into more focused case studies to gain more understanding from the leadership perspective.

As stated in chapter 1, healthcare leaders that considered merging with another organization but decided against the merger or those opposed to mergers in general could be part of a different type of merger research. This perspective would be interesting to include in future research, pending an effective strategy to identify such individuals.

Implications

As stated in chapter 1, Barilla et al. (2019) called for bold leadership to transform healthcare, which has been said about mergers. The role of the leader is pertinent to the nuances of healthcare mergers and the future of the healthcare industry as a whole. Leaders are the change agents that drive mergers and healthcare at many levels. Leaders address challenges, provide innovative strategies to improve healthcare, and find solutions (Barilla et al., 2019). This is paramount for this research and provides for positive social change at the organizational level initially, then positive social change across the healthcare industry.

Leadership experience provides for future implications by adding to the body of knowledge. The leader is the origin for most mergers because they drive the decisions to merger or bring about collaborations for these organizations yet there is still no merger research on the leadership perspective or understanding this experiential phenomenon and how to understand this will impact the field of merger research.

Therefore, understanding the leader's role, behavior, and actions will give future leaders insight into the necessary strategies, techniques, knowledge base, lessons learned, and help them alleviate some of the challenges that will occur even with the best planning practices that anyone can devise.

Implications for Practice

Based upon the research findings, when a healthcare organization is in the position to consider undertaking a merger or any kind they should consider the following information that has been collected from this study participants:

- Leaders should conduct due diligence in the strategic planning for the merger by thoroughly understanding the merger process and all that it will entail because there has to be a clear strategic rationale to focus on
- Leaders have to move forward with a well informed team that will be able to address all issue concerning legal requirements, financial historical information for all entities, share trends that span 5, 10, 15, and even 20-year projections, knowledge regarding state regulations are key to the process, and knowing the organizational culture
- Leaders have to set goals and know what they want to accomplish in the merger deal including the future governance
- Leaders have to have strong communication skills and be ready to inform many stakeholders at various levels regarding the past, present and future position for the organization(s)

- Leaders have to be confident and consistent in their leadership with the ability to earn and retain the trust of the organization that they are able to lead them to a positive outcome

These recommendations come from current leaders that have successfully completed the merger process, 75% of these leaders have gone through mergers more than once and have noted that every merger experience is different, but they are for the most part all very challenging and stressful but can be easier with very diligent planning and the ability to adjust when necessary or make hasty decisions at a moment's notice.

Implications for Social Change

The objective of this research was for healthcare leaders will be able to make knowledge-driven decisions using outcome-based or theory-supported examples based on what was proven to work based upon the findings of this study to improve the health of society. Future leaders may be better equipped to handle social change in the healthcare field with this knowledge. With more successful merger planning and experiences, the healthcare community could be provided with better quality of care and sustained healthcare operations since this study shows leaders how to continue to keep operations flowing during the merger process. With greater understanding of the experiences of hospital leaders have around healthcare mergers social knowledge is shared and able to be applied by other because experience can be a source of learning for social change as taught by Johnson (2020) and Kolb (2015).

Conclusions

The goal of the study was to explore the experiences of healthcare leadership before, during, and after healthcare mergers. The focus was on their lived experiences from the planning stage, any challenges, the integration process, and finding common factors with regards to strategies and maintenance of business operations. A greater understanding of these experiences was vital to this research of leadership lived experiences and the causality for future mergers, which is constantly evolving.

Hughes mentioned characteristics of hospital mergers being unique in various respects such as location, size, resources, culture, and business process (Hughes, 2020). The leaders that were interviewed in this study agree with the fact that all mergers are different, but they also find many common issues and areas of concern. This research was aware of the nuances listed above and discussed these topics with the study participants as planned in chapter 3 leading to the conclusion that the leader’s experience is very valuable to the field and the body of knowledge. The leadership lens is vital to all aspects of the healthcare merger for onset to conclusion of the phenomenon. Future leaders or leadership thinking about merging healthcare organizations may improve the merger experience and awareness of the merger process from this research study.

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Appendix A: Megamerger Deal Values

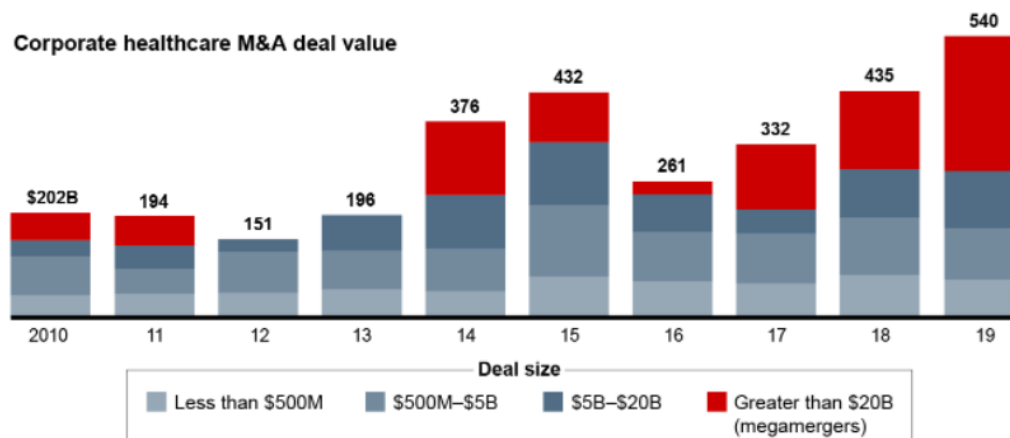
Megamergers Boost Healthcare M&A to New High

Corporations are using M&A to grow revenue, which public markets prize.

By Nirad Jain and Kara Murphy

March 23, 2020

Megamergers accounted for 2019's record-high disclosed deal value



Notes: Excludes spin-offs, add-ons, loan-to-own transactions and acquisitions of bankrupt assets; based on announcement date; includes announced deals that are completed or pending, with data subject to change; deal value does not account for deals with undisclosed values
Sources: Dealogic; AVCJ; Bain analysis

https://www.bain.com/insights/megamergers-boost-healthcare-ma-to-new-high-snapchart/

Appendix B: Interview Questions

IQ1: What type of merger was it?

IQ2: What was your role in the hospital or healthcare merger?

IQ3: What guidance were you provided to assist in the merger process?

IQ4: What was your experience from the decision to merge through completion?

IQ5: What are some lessons learned from the hospital merger process?

IQ6: Can you share your perspective on the merger process?

IQ7: What knowledge or expertise should a leader have prior to embarking onto a merger?

IQ8: What suggestions would you recommend to future leaders embarking upon a merger?

IQ9: Would you have found value in training to prepare for mergers as a leader?

IQ10: What would you have preferred to know in preparation for such an endeavor?

Appendix C: Study Invitation Email

Dear Colleague,

This is a new study about the lived experiences of healthcare leadership regarding the decision-making process during the merger phenomenon for better understanding from this perspective. For this study, you are invited to describe your experiences and share lessons-learned from your own perspective.

About the study:

- Looking for 10-15 volunteers
- The published study will use randomly selected numbers not names to protect your privacy
- Includes healthcare organizations that have completed mergers in the past 5 years

Time Commitment:

- One 30-minute phone interview that will be recorded for accuracy
- 45-minute review of transcribed interview

Volunteers must meet these requirements:

- Adult - 18 years old or older
- C-Suite Level Leader that recently participated in a healthcare merger
- Directly part of the decision process of a healthcare merger
- In the New England Area of the United States

This interview is part of the doctoral study for Cassandra Speed, a Ph.D. student at Walden University. Interviews will begin in the spring of 2023.

Please respond to this email to let the researcher know of your interest. You are welcome to forward it to others who might be interested as well.

All potential study participants may contact me directly via email at [redacted].

Thank you,

Cassandra Speed