Distributed versus centralized leadership in the implementation of a Canadian integrated care initiative

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17th International Conference on Integrated Care

Wednesday, May 10, 2017

Study Team

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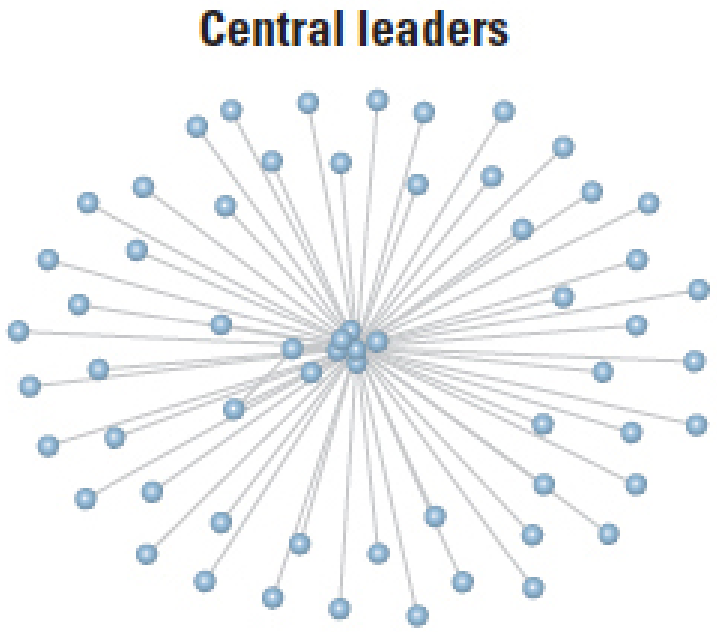
Background

Traditional leadership

- Centralized power at senior levels



- "Trickle-down" effect of strategy and vision

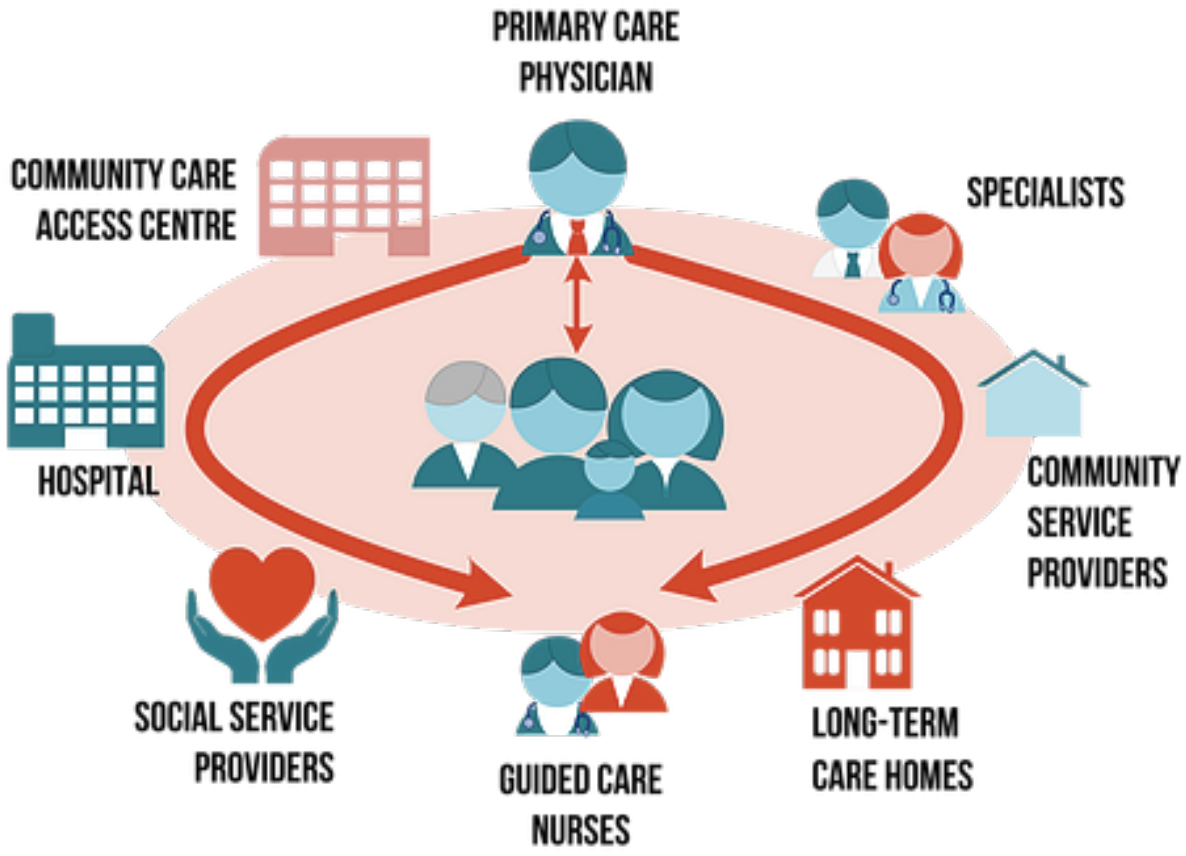
- How has this model impacted implementation of integrated care networks?
- Why should alternatives be explored?
- Evidence growing of competing leadership models[1,2]

“Alternate” Models of Leadership

- ‘Post-heroic’ leadership[3,4,5]
  - Distributed, collective, shared, emergent, complex
- Distribution between formal and informal leaders
  - Distributing leadership to clinicians,[6] designated change agents[2]
- Planned vs. emergent /aligned vs. misaligned purposes [6,7]
- Structural centrality vs. distribution of leadership at multiple levels

Context - Health Links (HLs)

- Better care for patients with highly complex needs
- Focus on care coordination and the development of joint patient/client-centred care coordination plans
- “Low rules” to stimulate self-organization



http://bsnhealthlink.org/what-is-health-links/

Objectives

- Primary aim: Explore leadership approaches in low-rules HLs context
- Secondary aim: Understand potential benefits and challenges of different leadership approaches in integrated care contexts

Methods

- Multi-method evaluation of province wide integrated care initiative
- Qualitative portion: **Leader/provider perspectives**
- 6 case studies across 3 regional health authorities (RHA)
  - 3 HLs in RHA 1: 21 leaders; 9 providers
  - 2 HLs in RHA 2: 11 leaders; 8 providers
  - 1 HL in RHA 3: 3 leaders; 3 providers
- Data collection: Winter 2016-Spring 2017

Results

Network Leadership Structure in HLs

Results

Benefits of Centralized Leadership

- **Sending a clear message prioritizing HLs and allocating resources**
- **Keeping the initiative ‘on track’**

The senior leadership reflects the direction of the organization. So if the organization has changed an emphasis... If you don't get that same support, it's very difficult and it will fall apart... And if you don't have that support, it's like sort of working with Jell-O. There's nothing to really hold onto. ***[RHA2]***

Results

Challenges of Centralized Leadership

- **HL lead's vision not in alignment with partners; incongruent perspectives and priorities for patient care**
- **Strong resistance to change; Need to 'demystify' the initiative**
- **HL clinicians not involved, therefore later on fail to see value**
- **With no distributed leadership in place at the physician level, no incentive for [FHTs] to engage**

…It's very hard to engage with the diverse population of primary care providers in the community when you have a "product" that you're trying to sell to them and they don't understand the concept and there's no real net gain to them. ***[RHA1]***

…They don't even know what Health Links is. And Health Links means a hundred different things to everybody. ***[RHA1]***

Results

Leadership across HLs

- Differences between HLs in terms of *intent* to develop shared leadership across the HLs network
- Some HLs attempted a planned strategy of distributed leadership but were unsuccessful in follow-through
- Ultimately resulting in confusion around frontline providers' role in and understanding of HLs

I’m not sure who the leader is here. Is the leader the Ministry, the hospital, the Health Link manager, the steering committee? Like who would you say this question relates to? Who is the leader of the Health Link program? ***[RHA1]***

Results

Informal Distributed Leadership

- **Emergent distributed leadership:**
  - Creating an embedded HL role in collaboration with senior leadership allowed for increased staff engagement
- **Clinicians adopting a championing/guiding role**

In terms of clinical engagement and leadership, we've had more informal leadership like within the organization. Like the social worker on the medical side of the hospital who I called to say help me, and she talked me through. But I mean she doesn't have time for that either. ***[RHA2]***

Limitations and Future Work

- Case studies are not generalizable beyond the Ontario, Canada context
- Interviews conducted at planning/implementation phase which affects the priority of the interview respondents
- Data collection not complete for all HLs

- Results help set a foundational groundwork from which to further explore distributed leadership in integrated care

Key Discussion Points and Next Steps

- Centrality as **a necessary but insufficient** condition
- Efforts to implement 'low rules' integrated care initiatives may require more proactive approach to leadership
- To develop distributed leadership, senior leadership must facilitate context for ownership of the implementation project
  - Education, awareness, knowledge-sharing → **Learning networks**
- Balance needed between fully centralized and fully distributed ("leaderless") models
  - What would this look like?

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