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

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BACKGROUND

Traditional notions of leadership involve centralized power at senior levels, with strategy and vision expected to "trickle down" via communication to operational levels. To date, evidence on how traditional centralized leadership impacts the implementation and functioning of integrated care networks is unclear.

"Alternate" Models of Leadership

Competing alternatives to the traditional leadership model have been emerging in the literature as viable options for sustainable organizational change, particularly in the healthcare field.[1,2,3] These theories posit that non-formal leaders are critical to the functioning of complex organizations and systems. Though many such models exist, **distributed leadership** has emerged as a particularly salient leadership style, defined by:

- Distribution between formal and informal leaders
  - E.g., Distributing leadership to clinicians,[4] designated change agents[5]
- Distribution of leadership at multiple levels (as opposed to structural centrality)
- Strategically planned *or* emergent organically through front-line processes[6,7]

OBJECTIVES

The key objectives of this research are as follows:

1. Explore leadership approaches in the context of "Health Links" in Ontario
2. Understand potential benefits and challenges of different leadership approaches in integrated care contexts

METHODOLOGY

Setting: Health Links (HLs) was established in 2012 in Ontario by the Ministry of Health and Long-term Care, as a novel approach to deliver better care for patients with highly complex needs. The aim of HLs is care coordination and the development of joint patient/client-centred care coordination plans. HLs was designed as a "low rules" approach allowing for self-organization and collaboration as determined by local partnering organizations

Design: Multi-method case study evaluation of HLs across 3 Local Health Integration Networks (LHINs). Data collected from organizational ***leaders*** and ***healthcare providers.***

6 case studies were conducted across 3 LHINs:

- 3 HLs in LHIN 1: 21 leaders; 9 providers
- 2 HLs in LHIN 2: 11 leaders; 8 providers
- 1 HL in LHIN 3: 3 leaders; 3 providers

Data Collection: Semi-structured interviews were conducted with organizational leaders and providers beginning February 2016 and continuing through Spring 2017.

Qualitative data collection and analysis were guided by the "Context and Capabilities of Integrated Care"[8] framework.

FINDINGS

Leadership Structure in HLs:

HLs adopted a highly centralized formal leadership structure:

1. The 'lead' organization for each HL determined the partnership structure, including identifying "core" (or founding) and "peripheral" partners
2. Lead organization also determined which partner organizations would actively participate in governance committee
3. The governance "steering" committee was composed of partner organizations' respective CEOs, senior management members, and the HLs lead.

Benefits of Centralized Leadership Model

- **Senior leadership allow prioritization of 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. **[LHIN2]**

Challenges to Centralized Leadership Model

- **Vision alignment: incongruent perspectives on patient care**
- **Strong resistance to change**
- **Need to 'demystify' the initiative**
- **HL clinicians not involved, therefore later on fail to see value**

> 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. [LHIN1]**

> 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? [LHIN1]**

Opportunities for Distributed Leaders in HLs

- **"*Pockets*" of 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.

IMPLICATIONS

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

ACKNOWLEDGEMENTS

This research was supported by a grant from Ontario's Ministry of Health and Long-Term Care (MOHLTC) to the Health System Performance Research Network. The results and opinions reported here are those of the authors. No endorsement by the MOHLTC is intended or should be inferred.

References available upon request