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CONFERENCE ABSTRACT

Effective Organizational Leadership in the Implementation of Integrated Care; Lessons from 9 cases in the iCoach Project

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G. Ross Baker[1], Jay Shaw[2], Jennifer Gutberg[1], Tim Kenealy[3], Peter Carswell[3], Mylaine Breton[4], Louise Belzile[4], Jean-Louis Denis[5], Walter Wodchis[1]

1: University of Toronto, Canada;
2: Women's College Hospital, Canada;
3: University of Auckland, Canada;
4: University of Sherbrooke, Canada;
5: Ecole National d'Administration Publique, Canada

Introduction: Policy makers in many countries are encouraging the development of integrated care strategies and the development of new models of integrated care. These new models require changes at a clinical or service level, organizational level and system level with strong leadership necessary at all three levels. Despite the key role of leadership in these efforts, there has been only limited study of what organizational leadership approach is successful in different contexts for integrated care.

Theory/Methods: This paper analyses the organizational leadership behaviors and strategies in the iCOACH project (Integrated Care for Older Adults with Complex Health Needs) for 9 integrated care projects in 3 jurisdictions: New Zealand, and the Canadian provinces of Ontario and Quebec. Data are derived from interviews with leaders, policy makers and providers in these cases. We draw on institutional logics and institutional entrepreneurship theories to explore how leaders engaged external stakeholders and developed strategies to optimize the effectiveness of integrated care within and between their organizations in these different contexts.

Results: There are concerted efforts to develop integrated care models of community based primary health care in all three jurisdictions. However, the policy environments vary in the latitude and resources provided to organizational leaders to develop organizational forms and networks. In Ontario and New Zealand there have been considerable variations in the nature of integrated care organizations and networks, while in Quebec the government has mandated new organizational forms and specified their relationships with other providers. Preliminary analysis of our data suggests that institutional entrepreneurship takes different forms in response to these environments, and other policy issues, such as the development of health care resources for Maori have also influenced the support and direction of integrated care. There is also variation in the entrepreneurial styles within and across these organizations, balancing the need for external stakeholder management and developing local capability for more integrated care based on the vision for the organization.

Discussion: Leadership is a critical resource in the development of new organizational forms and in carrying out the negotiations needed to garner the resources and legitimacy necessary for effective

organizations. However, leadership strategies can vary in different contexts, and the types of institutional entrepreneurship necessary for building these organizations varies as well.

Conclusions: Understanding successful leadership strategies and entrepreneurial behaviors in different contexts helps to illuminate the similarities and differences across different policy and organizational environments.

Lessons learned: While leadership is essential for integrated care, there is no single model that has been successful across the contexts we have studied.

Limitations: The analysis of the data described here is still underway. Our data is derived from cases in three jurisdictions and these are likely not fully representative of the range of policy and organizational environments.

Suggestions for future research: Further research on the leadership strategies that are successful in different environments is needed to confirm and extend the analysis from the 9 cases we have studied.

Keywords: integrated care; leadership; institutional logics; institutional entrepreneurship; distributed leadership

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