Making Integration Work Requires
More than Goodwill

Linda Smyth

Abstract

Over the past three years I have had the opportunity to be involved in two integration projects regarding cancer services. Both projects crossed jurisdictional, geographical and healthcare-provider boundaries and used cooperation and collaboration to work toward the goal of an integrated, quality, multi-disciplinary, seamless, patient-centred approach to cancer care. The projects have provided a perspective of what worked well and what could be improved when integrating healthcare services across organizational and provider boundaries. Governance emerged as a key determinant of project progress and successful change.

Background

Each project started at a different place along the project management continuum, with variations in the involvement of key stakeholders, relationship histories, existing infrastructures

and organizational partners. This presented a learning experience and identified challenges and benefits of these different situations regarding governance. The literature offers several perspectives, including suggestions and recommendations on why, and under what conditions, some approaches may have been more effective than others when working and governing across boundaries. The following discussion shares the experiences with these projects and how some of these concepts apply.

What Is Governance?

There are many descriptions of governance and what is required for effective governance. Goodwin et al. (2004) explain that the type of governance is influenced by the form the network takes and that it includes the activities that influence the work, structure, culture and resourcing of the organizational network. In addition, even if mandated, voluntary collaboration requires a full range of tools such as authority, inducement, persuasion and standard-setting to be successful. In one project, several existing structures tended toward authority and formal lines of communication dictated by the structure, and used inducement as an incentive. The other project's structure was much flatter,

with resourcing being a priority. In both cases, existing cultures were a significant influence.

Denis et al. (2006) discuss three models of governance in healthcare organizations – agency, stakeholder and stewardship. These models share five core functions of governance:

- Generating intelligence;
- Formulating mission and vision;
- Resourcing and instrumentation;
- Managing relationships; and
- Control and monitoring.

We quickly found that although common goals and objectives were a great start, there were many ways to reach a destination. It was during the journey that issues arose and differences in culture surfaced. Governance needed to provide the framework and leadership for momentum and support to accomplish the integration of services.

Our projects experienced all of these functions to a greater or lesser extent.

Stoker's (2004) description of governance is that of guiding collective decision-making and groups of individuals or organizations making decisions that may be private or public. This definition is representative of a key requirement we encountered with the projects – that of needing a guide for collective decision making. As the integration projects crossed organizational and jurisdictional boundaries, multiple stakeholders were engaged. Although goodwill and focus on patient-centric care got stakeholders to the table, once there they had to make decisions about how integration of services would be achieved. In some cases there were established processes between stakeholders. However, integration could require implementation of a new dimension, requirement or standard; addition, replacement or elimination of a process; the work to be done differently; or a hand-off to a different stakeholder. We quickly found that although common goals and objectives were a great start, there were many ways to reach a destination. It was during the journey that issues arose and differences in culture surfaced. Governance needed to provide the framework and leadership for momentum and support to accomplish the integration of services.

Several aspects of governance were key to the success of our projects. The first was decision-making. Since the projects were provincial, experience confirmed that integrated decision-making was required when organizational and jurisdictional boundaries were crossed. Pope and Lewis (2008) indicate that decision-making processes in partnerships are more difficult due to the range of voices that need to be considered and the negotiation around the provision of resources. With multiple partners; organizational, jurisdictional, and public and private provider boundaries; unique cultures; finite resources; and multiple bodies of professional knowledge and practices, as well as business processes, the decision-making process was complicated. What became evident was that without a clearly defined infrastructure and decision-making process, decisions progressed through each partnering organization's process, adding to the complexity and time required. Questions and problems would recycle through unclear processes, slowing decision-making and delaying project progress and deliverables. In addition, each partner's process was influenced by the need to protect the organization's mandate, viability or turf, and this could challenge the ability to accommodate the broader perspective and mandate of the continuum-of-care project. Early in the integrated planning and implementation process, clarity was required on the types of decisions to be made, by whom and within what parameters. This decision-making process then needed to be understood and used by the partners. Ansell and Gash (2007) indicate that clear and consistently applied ground rules reassure stakeholders that the process is fair, equitable and transparent, with negotiation that is real and excludes backroom deals. Strong leadership, with integrated governance and appropriate processes, enables the partners to participate in decision-making and focus on the comprehensive vision of the care continuum from the patient's perspective.

In addition to decision-making, Philpott (2008) mentions two other qualities required of a governing board that were key in our project experience. First, the board is a positive, supportive venue for sounding, advising and questioning. This was key in our projects, particularly when we received new information or when unforeseen situations arose. The result was the ability to revisit the vision, confirm the mandate and direction, or adjust the work plan, establishing where we were, where we needed to go, and if we were we on the right track.

The second quality of good governance is the ability of board members to recognize that once appointed, their duty is to the board and the "bigger picture," and not only to represent their constituency (Philpot 2008). This was a challenge with our projects, as board members represented organizations (each with a mandate) or represented professionals for whom collaboration could pose a threat to their autonomy or established practice, or could potentially affect their income. This created challenges even if the impact was perceived versus real. To get beyond this required a willingness to hear another point of view, a strong commitment to patient-focused care and a lot of communication, negotiation and hard work at multiple levels.

The next governance attribute identified by several authors

was leadership. Philpott (2008) indicated that boards need to make decisions that will force the organization to stretch beyond its perceived capacity. This is very relevant to integration. Our projects required stakeholders to move beyond past history and experience, and step outside the silos and away from the protection of familiar turf, organizations, professions or jurisdictions. Yet this is easier said than done! Strong and committed executive and medical leadership was needed, combined with solid planning, communications and change management. Together these enabled stakeholders' engagement, support and increased commitment to the new integrated vision.

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Goodwin et al. (2004) also point out that leadership is to be found at every level in organizations and that leaders should be looked at as "boundary spanners." The authors indicate that other skills required for integrated governance include process initiation, negotiation, diplomacy, problem-solving and strategic development, tact, and the ability to move between accountabilities and motivate others. The strong commitment of the project and front-line staff and physicians from across the province to patient-focused care made them "boundary spanners." It enabled them to work together, share ideas, problem-solve and make suggestions that moved the provincial agenda forward.

In the bigger picture of governance, Forest et al. (1999) describe two issues that policy makers must resolve as they move toward integrated health systems governance. These are the degree of autonomy each integrated system will have in decisions and the balance between the values and interests of internal and external stakeholders. The authors describe the need for a governance model that would serve the interests of the community while preserving the autonomy of the individual health institutions/systems. In the projects were a number of independent providers who placed a high value on autonomy. This needed to be considered in the partnering relationships, governance structure and leadership roles. The other challenge was balancing the interests and values of internal and external stakeholders involved in the continuum of care. We managed this in a variety of ways: ensuring committees were inclusive of stakeholders, incorporating an advisory group into the infrastructure, adding physician specialists who consulted

and championed ideas and processes with their professional colleagues, and ensuring both executive and medical leadership within the project. In one project, the medical leadership incorporated a quality assurance program involving a multi-disciplinary physician group that improved the quality of patient care by resolving issues from across the continuum and not simply moving them downstream.

Why Is Governance Needed When Integrating Care?

System-wide changes and restructuring of healthcare, the increasing need for public accountability and barriers impeding effective governance are a few of the influences for the Canadian Council on Health Services Accreditation (CCHSA) new governance strategy (Taber and Pomey 2008). Care paths and integration of health services that cross organizations, jurisdictions, geographical boundaries, and public and private providers require collaborative relationships. Healthcare is part of an increasingly complex and interconnected world, and organizations can no longer operate in isolation (Bullivant et al. 2008b). On the other hand, Ansell and Gash (2007) believe that increased specialization and distribution of knowledge, combined with complex and interdependent infrastructures, also increase the need for collaboration and that these collaborative processes require collaborative governance. These all demonstrate the increased need for integrated governance.

The health system needs to deal with complex health issues, and organizations are searching for how best to deliver care as the existing silos struggle in this new environment (Jackson et al. 2008). Bullivant and Deighan (2006) suggest that for a board to achieve focused decision -making and deliver on strategic objectives, it needs to consider all aspects of accountability and not govern in silos. Bullivant et al. (2008a) identified that problems often occur at the borders between organizations or teams when care is handed off. In our projects, patients indicated that a missed step or lack of service along the care path affected how they perceived the healthcare system and their satisfaction with the services provided. Duckett and Ward (2008) indicate that the critical elements of value as assessed by patients might include continuity of care, timeliness of access (typically wait times), their expectations of improvement, their experience (the way they are treated during the care episode) and the cost to the patient to access treatment, such as, travel and accommodation. Along the care path are many opportunities for the patient to fall between the cracks. Integrated governance ensures accountability between partners, as the number of transfers between organizations increases, and as the measurement of targets (e.g wait times) continue beyond organizational boundaries when the patient is handed off to other care providers (Bullivant et al. 2008b). The projects' goal to improve care along the continuum required integration of services across multiple providers

involving a number of hand-offs of the patient and/or their information. Issues were identified with hand-offs, including requirements and criteria, sharing of information, and the need to identify responsibility and accountability at each step.

In addition, patients' need for timely access and quality care requires a high level of organizational performance (Nininger 2008). Boards and their management staff make vital decisions, choices and judgments regarding resource allocation, programs and services that affect and safeguard patient safety (Fralick 2008). Typically our projects involved multiple hand-offs, all with the potential to influence access, wait times and patient safety. Governance needed to go beyond organizational and provider boundaries, integrating services to ensure effective, efficient and safe transitions in care. Governance provides the vision, leadership and commitment to extend health service integration (Jackson et al. 2008).

The integrated governance

model needs to engage key stakeholders effectively and in a timely manner. This requires clarity up front about the expectations of stakeholders and a commitment from them if they are to be involved in the governance of a project. Incentives may be required to encourage participation.

Challenges to Establishing an Integrated Governance Structure

There are many challenges with the governance of integrated initiatives. Nininger (2008) suggested that governance may not have been a priority, due to the complexity of the delivery system in healthcare that includes lines of accountability and responsibility, which are difficult to understand, combined with a lack of investment in building governance and leadership competencies. Ansell and Gash (2007) indicate that imbalances in power produce distrust or weak commitment and that it becomes problematic when important stakeholders do not have the organizational infrastructure to be represented in the collaborative governance processes. With our projects, some patient populations and physician groups did not have the support to facilitate their participation in the governance process. This limited the participation of some stakeholders.

Another potential barrier is that some stakeholders, due to their size or resources, may not have the time, energy or liberty to engage in time-intensive collaborative processes (Yaffee and Wondolleck 2003). During our projects, we often heard from busy stakeholders that they were challenged to participate

because of the time demands on physicians in private practice and senior executives with multiple priorities. This affected governance and put pressure on the project, resulting in delays in progress and decision-making and the resolution of project issues. The integrated governance model needs to engage key stakeholders effectively and in a timely manner. This requires clarity up front about the expectations of stakeholders and a commitment from them if they are to be involved in the governance of a project. Incentives may be required to encourage participation (Ansell and Gash 2007). In our projects, we provided some financial remuneration for fee-for-service providers if participation resulted in lost income.

So What Is Good Integrated Governance?

Bullivant and Deighan, authors of the *Integrated Governance Handbook for the National Health System in the United Kingdom* (2006), describe integrated governance as systems, processes and behaviours used to lead, direct and control functions to achieve organizational objectives, safety and quality of service. They believe that integrated governance requires strategic thinking and dynamic risk assessment and suggest there are eight elements that constitute a high-level governance framework. These eight elements of governance include:

1. The concepts of sustainability and resourcing;
2. Efficient, economic. efficacious and effective services;
3. Compliance with all authorizations (e.g health, safety, drugs, etc)
4. Meeting standards (e.g. national targets) and guidelines;
5. Commitment to quality reflected in clinical governance;
6. Partnership with local healthcare economies;
7. Communication with stakeholders, including involving the patients and the public in planning; and
8. Ongoing board development.

Barker (2004) indicates that effective boards are critical to the success of organizations and set the strategic tone for the organization; they provide leadership and focus on priorities while creating forums for challenging debate and are unified by a sense of collective responsibility.

At the 25th International Conference of The International Society for Quality in Health Care (2008b), Bullivant et al. identified some key how-tos when governing between organizations. The following items were most relevant to our projects:

- Governance reflects the type of relationship;
- Agreement on, of, or between:
  - Common values, outcomes and measures;
  - Changes in the relationship or expectations;
  - Appointment of an arbitrator to handle partnership disputes;

- Decisions to be shared and tracked to ensure delivery of actions;
- Sharing information that will provide early warning of variances; and
- Completion of actions and commitments.
- Timely sharing of potential risks; and
- Sharing of common risks and escalation plans, and risks or failure of partners or suppliers to deliver.

In addition to these items, at the project level, governance was needed to:

- Provide a clear vision of the objective;
- Position the project strategically, identifying and mobilizing stakeholders;
- Ensure accountability across and within organizations, with clear roles and responsibilities;
- Deal with the politics and potential pitfalls with key stakeholders, encouraging transparency;
- Secure the resources to ensure project success;
- Remove barriers to facilitate progress;
- Provide a forum for open discussion of issues, risks, successes and problem resolution; and
- Negotiate and clarify a decision-making process that is clear, timely and workable.

What Is the Future for Integrated Governance?

In Crossing the Quality Chasm: A New Health System for the 21st Century (Committee on Health Care in America 2001) the board was identified as a key player in shaping the system of the future. Brian Schmidt (2008) describes the Qmentum approach and how it has brought the spirit of knowledge, innovation and purpose to healthcare governance, ensuring that the patient is, and always will be, first and the focus of healthcare. Moore (2007) believes that the real work of the board is creating wisdom from knowledge gained through information and data and that the governance model will help this wisdom lead an organization into a positive future. This requires that the board value the perspective of ownership, long-term thinking and foresight; incorporate time for reflection and critical thinking to create clear criteria; empower management; practise precision thinking (identification of what is prudent and ethical); act as an information filter, recognizing what is needed for monitoring and decision-making; and fight inertia and "sacred cows." Policy governance is a tool to help boards govern more effectively. This description of governance reflects the strong need for visionary leadership and longer-term thinking as a part of the governance model.

With the integration of health services, effective governance between organizations is required. Alberta is well positioned with its provincial health organization to make a difference by integrating services based on patient-focused care. Provincial projects with multiple stakeholders, providers and care sectors add to the complexity of providing services and require effective integrated governance. Qmentum, the new accreditation program from Accreditation Canada launched in February 2009, places a greater emphasis on health system performance and accountability. It has recognized the importance of good governance as an underpinning of organizational performance (Schmidt 2008) and has created a governance structure based on five core functions summarized below:

- The use of knowledge in the design and implementation of goals and to guide organizational adaptation;
- The creation of long-term goals, a vision and values to guide governance and the actions of the organization;
- The need to ensure the board's and the organization's internal development to support the achievement of the vision;
- The identification of and support for relationships with external and internal stakeholders to achieve organizational goals; and
- The need for processes to control and monitor performance, organizational adaptation and organizational culture.

The literature and experience in working across boundaries have established the need for integration of governance when integrating health services. This will require, as with integration of health services, a new way of thinking, new approaches and a new framework. Bryson et al. (2006) indicate that collaboration may be necessary and desirable, but evidence suggests it is not easy. Similarly, the journey to integrated governance will have its challenges. It is, however, key to successful integration of health services. Boards need to stay focused on the core functions and remember to question what difference will it make to the patient. HQ

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