

MODULE

4

Information Management

A System We Can Count On

Integration: A Range of Possibilities

The Health Planner's Toolkit

Health System Intelligence Project – 2007

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Health System Intelligence Project (HSIP)

The Health Planning Toolkit is produced by the Health System Intelligence Project (HSIP). HSIP consists of a team of health system experts retained by the Ministry of Health and Long-Term Care's Health Results Team for Information Management (HRT-IM) to provide the Local Health Integration Networks (LHINs) with:

- Sophisticated data analysis;
- Interpretation of results;
- Orientation of new staff to health system data analysis issues; and,
- Training on new techniques and technologies pertaining to health system analysis and planning.

The Health Results Team for Information Management created the Health System Intelligence Project to complement and augment the existing analytical and planning capacity within the Ministry of Health and Long-Term Care. The project team is working in concert with Ministry analysts to ensure that LHINs are provided with analytic supports they need for their local health system planning activities.

Report Authors

Sten Ardal

John Butler

Richard Edwards (Module 4 Lead Author)

What Integration Means – The Integration Consultant’s Challenge

Emily is an integration consultant on the staff of a local health integration network (LHIN). Several cardiac care stakeholders have asked the LHIN to work in partnership with them to develop a more integrated cardiac service system – but as Emily begins to discuss the idea of integration with other local health service providers and consumers, she encounters a bewildering array of definitions of integration and a range of anxieties about what integration will involve.

Some health service providers are concerned that existing successful voluntary efforts to coordinate cardiac services will be ignored in favour of a LHIN-driven approach. Some consumers are concerned that integration will further reduce their influence over the care they receive. A number of consumers and providers also worry that a focus on integration of healthcare services will ignore the need for close working relationships between the health sector and other sectors aimed at improving overall cardiac health in the community. Still others believe a focus on integration is a “shell game,” meant to divert attention from the need for additional resources in the community.

Emily also encounters a concern that the LHIN may have an agenda for integration that it is not willing to share with the community, even though she knows the LHIN is genuinely interested in exploring all dimensions of the term “integration.”

While recognizing these concerns within the community, Emily also believes too much time and attention is spent on the traditional meaning of the term “integration,” which usually translates into winner and loser, big swallowing small, and changes in who has responsibility for the delivery of service. She believes in approaching the proposed cardiac service integration through a different lens – a lens that:

- Includes a focus on the perspectives of the client, the resident, the patient and the family, rather than focusing exclusively on the provider organization;
- sees integration as a way to remove obstacles to efficient navigation;
- sees integration as a way to foster the development and implementation of system-wide best practices;
- sees integration as a way to move forward with service delivery standards to promote good outcomes and eliminate duplication and inefficiency; and
- sees integration as a way to develop critical mass to fully maximize the use of skills, equipment and facilities.

In short, she sees well-planned integration as a way to create real transformation.

This Module's Purpose

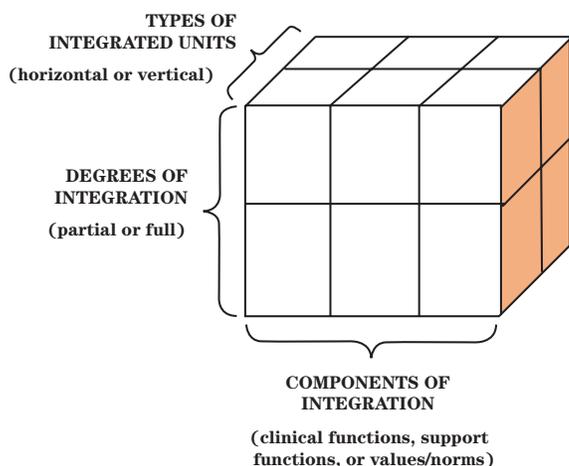
Local Health Integration Networks, a key part of the Ontario Government's vision for health care, will build on local experience of service integration to create an integrated health system. In carrying out this mandate, LHINs and their community partners have a stake in developing a shared understanding of integration as a set of options to improve the health care system.

To promote shared understanding, this module acquaints its readers with basic concepts that drive integration and with factors that lead to successful integration.

The module discusses goals that integration might serve, as well as organizational forms and strategies for achieving integration. It also provides a three-dimensional matrix of integration possibilities as a tool for documenting, planning, monitoring and evaluating integration (see Figure 1) and it analyzes four crucial influences on integration (see Figure 2).

The module also suggests how the dimensions of the matrix can be used to analyze integration through a "thinking path," starting with organizational goals and moving to (and through) the concrete tasks and task clusters that are the stock-in-trade of health service organizations.

Figure 1: The Integration Matrix

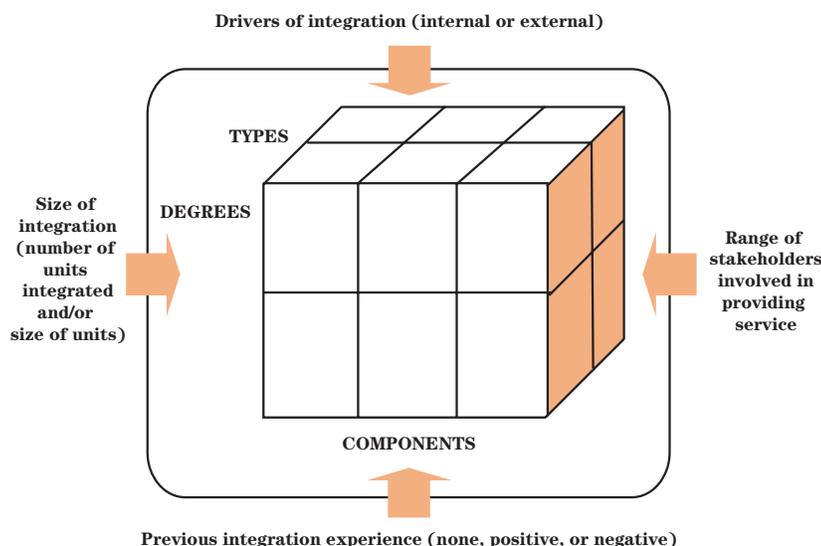


The Ontario Ministry of Health and Long Term-Care has defined integration in the *Local Health System Integration Act, 2006* in relation to specific actions as described in the following excerpt: "integrate" includes,

- a. to co-ordinate services and interactions between different persons and entities,
- b. to partner with another person or entity in providing services or in operating,
- c. to transfer, merge or amalgamate services, operations, persons or entities,
- d. to start or cease providing services,
- e. to cease to operate or to dissolve or wind up the operations of a person or entity, and "integration" has a similar meaning;

This module provides a broad conceptual base, and review of experiences with integration in other jurisdictions. This is intended as a resource for LHIN planners that will support integration activities and help address specific obligations defined in legislation. This module does not provide interpretations, policies, or guidance on compliance with the *Local Health System Integration Act, 2006*. The *Policies and Protocols Guide to the Local Health System Integration Act, 2006*, is being made available as an on-line guide for this purpose.

Figure 2: Four Influences on Integration



i Ontario's Local Health System Integration Act, 2006, Part I, Section 2(1)
Available at: www.e-laws.gov.on.ca/DBLaws/Statutes/English/06l04_e.htm#BK27

Section 1

What is Integration?

A report commissioned by Ontario's Ministry of Health and Long-Term Care provides a conceptual definition of integration:

"Integration is defined broadly to encompass the process of effectively managing the alignment of multiple systems of independent (and interdependent) organizations with unique goals and objectives to achieve three important outcomes that are central to the Ministry's transformation agenda:

- Ensuring that users experience services as seamless, where boundaries between organizations are not apparent to them;
- Improving the match between single services provided and the multiple needs of clients and families;
- Enabling effective and efficient use of system resources and capacity by optimizing system interactions across the system and across program silos."¹

Underlying this definition is the creative tension between differentiation and integration that characterizes almost every collective endeavour.

1.1 The Differentiation-Integration Paradigm

Organizations and systems have two requirements:

- the division of labour into various tasks to be performed (differentiation); and,
- the integration of these tasks to accomplish activities effectively and efficiently (integration).²

Integration is:

the management of dependencies among differentiated tasks within an endeavour, to produce the desired results.

If tasks in an organization or system were completely independent of each other, integration would be unnecessary – but in all but the simplest endeavours, tasks are dependent on each other.

In what ways are tasks dependent on each other? Several common kinds of task-dependencies are found within human endeavours – for example:

- **Task “A” must be completed before task “B” can begin;**
In health care for example, diagnosis is usually necessary before treatment can begin;
- **The results of task “A” must be useable by task “B”;**
In health care for example, it is not enough that a diagnosis is made. The diagnosis must be understandable to those responsible for treatment. Furthermore, it must be translatable into treatment and those responsible for treatment must be motivated to use the diagnosis to guide treatment.
- **Task “A” and task “B” must be carried out at the same time;**
In health care, for instance, physical aspects of cancer treatment must take place at the same time that clients receive help in dealing with their emotional reactions to the illness.
- **Task “A” and task “B” must both be carried out so that each makes the other effective;**
By way of example, some people with concurrent disorders (a mental illness and an addiction) will not receive effective treatment for either disorder unless both disorders are treated.
- **Task “A” is made up of sub-tasks that must be identified and managed;**
Determining what sub-tasks need to be performed, by whom and under what conditions, is a form of dependency management. For instance, the task of treating diabetes may involve sub-tasks carried out by a physician, a registered nurse, a pharmacist and a nutritional counsellor.

- **Task “A” and task “B” are both dependent on the same resource base;**
In health care, for example, most health services will rely on funding allocations from their Local Health Integration Network, from within a finite funding pool. Managing this dependency involves determining who gets what, and under what conditions.
- **The reputation of task “A” depends on the reputation of task “B.”**
In health care, for instance, a client may only consider the work of a case manager to be credible if the work of the person who referred the client to the case manager is credible.

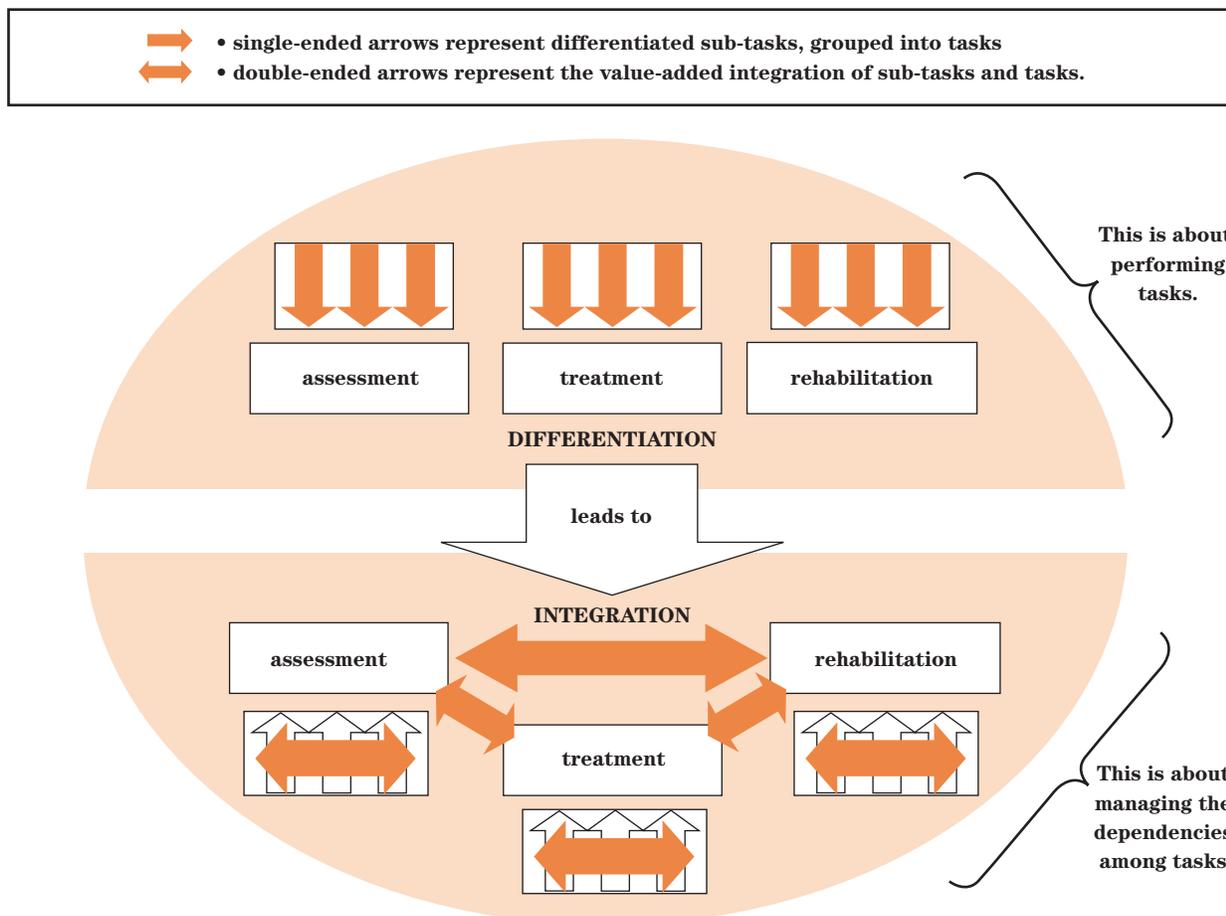
The word integration stems from the Latin verb *integer*, “to complete” – an appropriate root, since a collection of tasks that are not integrated can produce incomplete outcomes:

- some tasks may actually work against other tasks; and,
- some tasks may not be doable at all or may not achieve anything in the absence of timely completion of other tasks.

Given increasing recognition of the biopsychosocial nature of health and illness and of the complexity of care delivery, comprehensiveness and integration overlap as tools in meeting an individual’s physical, psychological, social and spiritual needs. Today’s views of health suggest that three components of care must exist, simultaneously and integrated with each other:

The relationship between differentiation and integration can be shown in graphic form (Figure 3).

Figure 3: Integration Flows from Differentiation



- *episodic care*: integrated care provided during a single episode of illness or risk to health;
- *disease management*: integrated care provided for a health disorder as a whole and not just specific episodes; and care for people who have several health disorders; and,
- *holistic care*: integrated care that recognizes the pursuit of health as well as the treatment of specific health disorders.

This broadened view of health and the consequent increased need for integration can be shown graphically (Figure 4).

Specialization in pursuit of health goals has tended toward greater dis-integration and fragmentation, beyond the capacity of any one person or health profession to manage. Serving the health of the whole

person thus requires integration of all parts of the health system.

1.2 Getting the Language Right

This module examines integration as *any form of managing dependencies among tasks*.

The term “integration” has sometimes been used to mean the most intense form of integration – the merger or amalgamation of organizations into a single organization. When used this way, the term is often contrasted with less intense forms of managing dependencies among tasks. Collaboration, cooperation, coordination, partnership and networking, for example, are sometimes considered forms of working together that are different from integration. In this module, however, all such terms will be considered variants of integration.

Figure 4: Connecting Integration with Comprehensive Health

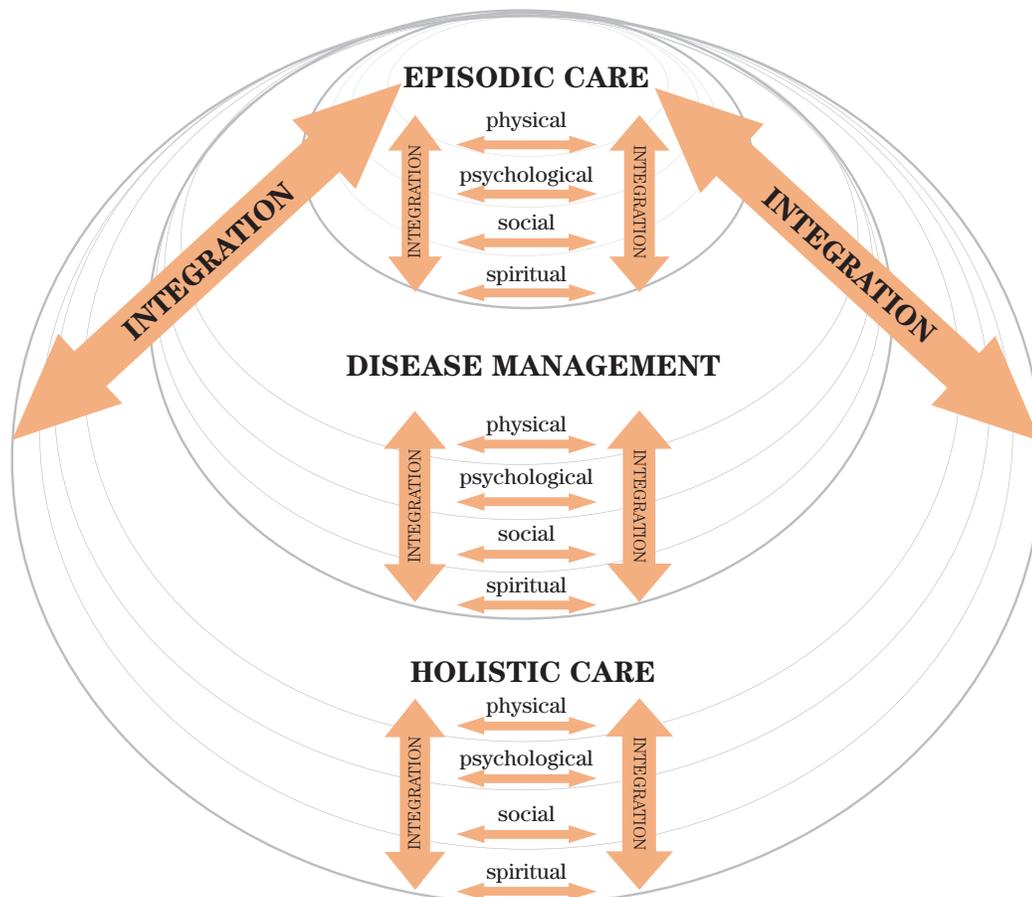
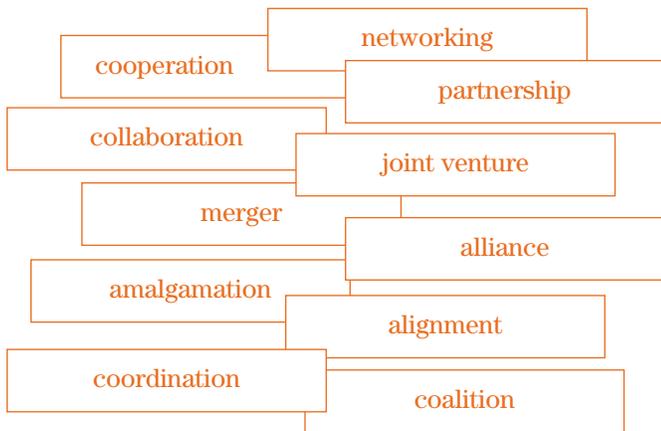


Figure 5: Integration-Related Terminology

The term **INTEGRATION**
(managing the dependencies among tasks) can include...



Achievement of health goals does not require that all parts of the health system must be integrated or that integration must be complete. The legislation that created and empowered LHINs (an Act to provide for the integration of the local system for the delivery of health services) does not permit that LHINs merge existing health organizations' boards. Unlike regional models in place in other provinces, LHINs will not be providers of clinical services, but will coordinate service delivery.⁴ Hospitals, long-term care facilities and other autonomous transfer payment agencies will keep their boards, although LHINs' integration authority allows them to compel programmatic mergers. Integration comprises many ways to create health systems that serve people's health needs more completely and comprehensively than disjointed processes and structures allow.³ LHINs have leeway in determining which kinds of integration are appropriate.

This module's broad definition of integration reflects the breadth that LHINs bring to the concept.

1.3 The Goals of Integration

Some authors state that the central goal of an integrated health care system is to coordinate services to patients across a range of care required to maintain, restore, or enhance the health status of clients.⁵ Ontario's Ministry of Health and Long-Term Care (MOHLTC) has stated that integration of services will improve the accessibility of health services to allow

people to move more easily through the health system.⁶ Implicit in this statement is the belief that increased accessibility will improve health status. But integrated systems may have other goals that – while not contradicting the health status goal – may be in tension with it. For instance, efficiency goals (less duplication and waste for example) may free up resources for use in increasing the health status of the population, but efficiency goals can be in tension with health status goals if a by-product efficiency is an actual reduction of health status.

Ontario's Local Health System Integration Act also identifies goals for integration, by defining the purpose of the Act itself:

"The purpose of this Act is to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by local health integration networks." 2006, c. 4, s. 1.

This section of the Act clearly states the government of Ontario's expectation that both health improvement and system efficiency goals will be considered important in an integrated health system.

Integration is not an ultimate goal. It is a means to achieve ultimate goals. Yet integration has gained enough prominence as a way to achieve other health system goals that it becomes an **intermediate goal** which should lead to ultimate goals.

It is essential to identify the goals of an integration effort before designing, implementing and evaluating it. It is also important to get buy-in to these goals, since shared goals are a key ingredient in many successful integration efforts.⁷

In achieving a goal there will be a series of processes or steps on the way to achieving the **ultimate goal**. Achieving each process or step becomes an **intermediate goal**. As well, there may be **immediate goals** that relate to preferred processes for how other goals will be achieved (through participatory decision making or through evidence-based decision making for example).

Goals that are relevant to integration:

- **ultimate goals** – generally having to do with improving health, or more efficiently providing service.
- **intermediate goals** – related to creation of specified processes and structures likely to lead to the ultimate goals.
- **immediate goals** – related to preferred processes for how other goals will be achieved, for example through participatory decision making or through evidence-based decision making.

Logic models for operational planning use the language of inputs, activities, outputs, outcomes and impacts to distinguish the series of processes and steps directed toward the ultimate goal,⁸ sometimes making a distinction as well between immediate, intermediate, and final outcomes. For more information on logic models see Module 1, *The Planning Process*, Appendix H, in the Health Planner’s Toolkit series.

The preamble to Ontario’s *Local Health System Integration Act* acknowledges that a community’s health needs and priorities are best developed by the community itself. This suggests that participatory and inclusive decision-making should be an immediate goal for integration processes. Module 5 in this Health Planner’s Toolkit series (*Community Engagement and Communication*) discusses community engagement in health planning and decision-making.

A related issue is the role of scientific evidence in integration decision-making.⁹ Making decisions based on best evidence may conflict with citizen decision-making, which might set different integration priorities.¹⁰ Module 2 in this Planner’s Toolkit series (*Assessing Need*), for instance, discussed the potential conflict between popular sentiments regarding need, and scientific procedures for determining need. As well, processes and criteria for decision making are discussed in detail in Module 6 in the Health Planner’s Toolkit (*Establishing Priorities*).

1.4 A List of Possible Integration Goals

A starter’s menu of integration goals might look like this (see Table 1):

Table 1: Integration Goals

	Process goals	Outcome goals
<p>Ultimate goals</p> <p>lead to</p>	<ul style="list-style-type: none"> • Increased efficiency • Evidence-based decision-making • Ongoing stakeholder engagement 	<ul style="list-style-type: none"> • Improved population health outcomes • Improved individual health outcomes • Holistic and personalized attention to health needs • Clients experience services as seamless: boundaries between organizations are not apparent • Improved access • Reduced wait times • Improved match between single services provided and multiple needs of clients and families • A sustainable health care system
<p>Intermediate goals</p> <p>lead to</p>	<ul style="list-style-type: none"> • Coordinated care • Continuity of care • Teamwork • Flexible service provision • Budget pooling • Participatory and inclusive decision making • Improved knowledge transfer • Shared understanding of issue(s) • Shared planning • Health needs assessment • Service inventory 	<ul style="list-style-type: none"> • Risk factor reduction • Cost reduction • Profit enhancement • Gain and keep market power • Shared values • Innovation
<p>Immediate goals</p> <p>lead to</p>	<ul style="list-style-type: none"> • Processes to produce intermediate and/or ultimate goals • Structures to produce intermediate and/or ultimate goals 	

1.5 Integration as Process and as Structure

Integration is often seen as an issue of **structure** – as a redefinition of the organizational walls that divide activities into work units, departments and agencies. However, structure is more like a pipeline than a box with a floor, a roof and four walls. Structure is meant to carry processes forward – processes defined as flows of interdependent task-related activities moving in the same direction. The job of the pipeline is to direct the flow of activities toward people-centred goals. Structure, processes and goals are all important, but structure in and of itself is merely the servant of the other two.

1.6 Integration in Ontario

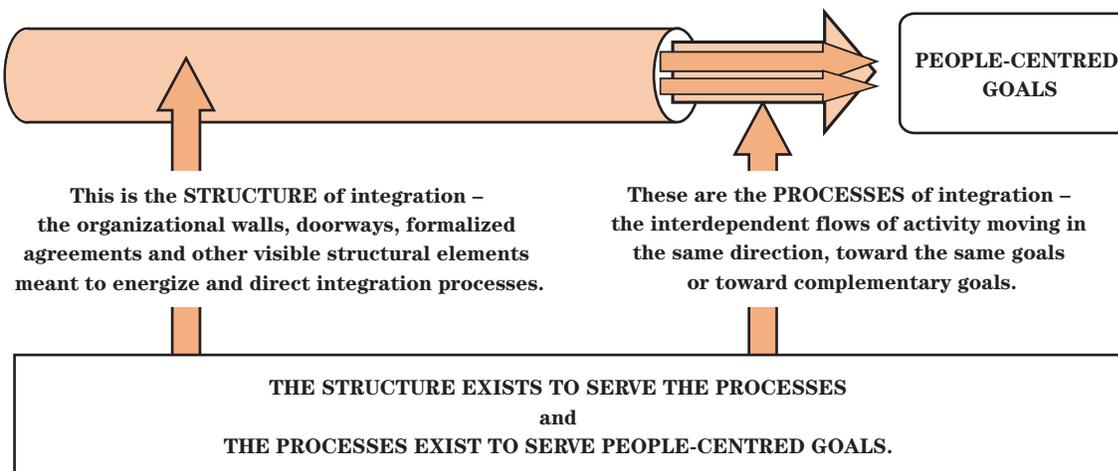
In Ontario, integration also has a technical meaning as defined in the *Local Health System Integration Act, 2006* (LHSIA). The Ontario Ministry of Health and Long-Term Care has prepared a document to help LHINS understand how obligations defined in the Act can be realized. This *Policies and Protocols Guide to*

The Local Health Integration Act, 2006 will be a crucial complement to this module for LHINS.

There are specific policy reasons for the legislative definition of integration in the LHSIA. This module does not address the relationship between government policy and integration priorities, in large measure because the LHSIA itself, and Ministry policy documents in support of the Act, address the relationship.

As well, integration as defined in the LHSIA has significant impacts on human services. These are anticipated and addressed in the LHSIA, but this module does not address human resource impacts that can result from integration. Module 7 (Establishing Priorities) in the Health Planner's Toolkit will identify how human resources factor into priority setting to support decision making.

Figure 6: Process and Structure



What Forms Can Integration Take?

2.1 A Matrix of Possibilities

The language of integration speaks of a continuum, from none to lots or from loose to tight, but it is more accurate to think of integration as the interaction of three dimensions:

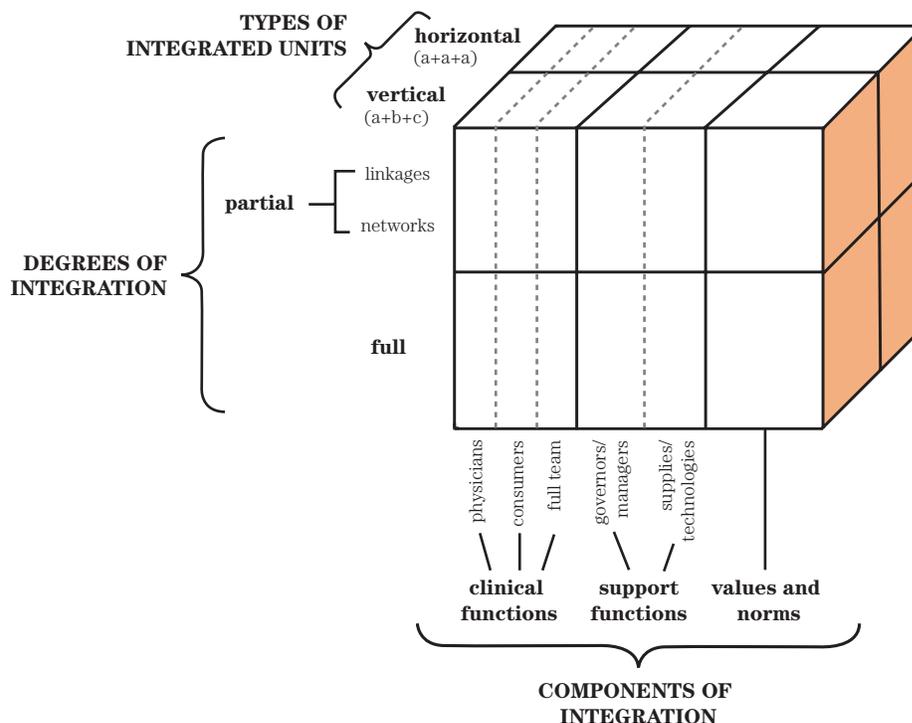
- **First dimension; Degrees of integration.** This relates to the degree of integration that takes place, and involves two clusters:
 - loose or partial forms of integration, in which separate organizational units work with each other. Variations of partial integration are described later in this module; and,
 - full integration (in which parts that work with each other are placed within a single organizational unit).
- **Second dimension; Types of integrated units.** This relates to whether similar units of activity are integrated (horizontal integration), or whether different but complementary units of activity are integrated (vertical integration).

- **Third dimension; Components of integration.** This relates to what kinds of activities are integrated, including:
 - clinical activities;
 - support activities; and,
 - norms and values.

Departments within an organization or a group of organizations can combine along these three dimensions to pursue their goals. Intersecting these three dimensions allows us to describe integration embodied in a variety of ways toward various ends – for instance:

- A community network to provide shelter to people who are homeless might be characterized as a partially integrated (network-based) horizontally-related collection of community services organized toward the narrowly defined goal of providing shelter by coordinating among themselves overnight beds for people who need them.
- This might be contrasted with a fully integrated, vertically-related collection of services, ranging from the provision of short-term beds to welfare assistance,

Figure 7: The Integration Matrix



all organized under the auspices of a single large institution working toward the broadly defined goal of providing shelter, by having social services within the same building as emergency shelter beds.

2.2 First Dimension in the Matrix: Degrees of Integration

Degrees of integration exist along a continuum from **segregation** (the absence of any form of integration among services or units) to **partial integration** (linkage-focused or network-focused integration) to **full integration**.

Implied in the description of these degrees of integration relationships is a subjective “closeness of working.” At one end (partial integration) is a more loosely knit set of relationships based on voluntary membership. At the other end (full integration) is a tightly integrated organization.

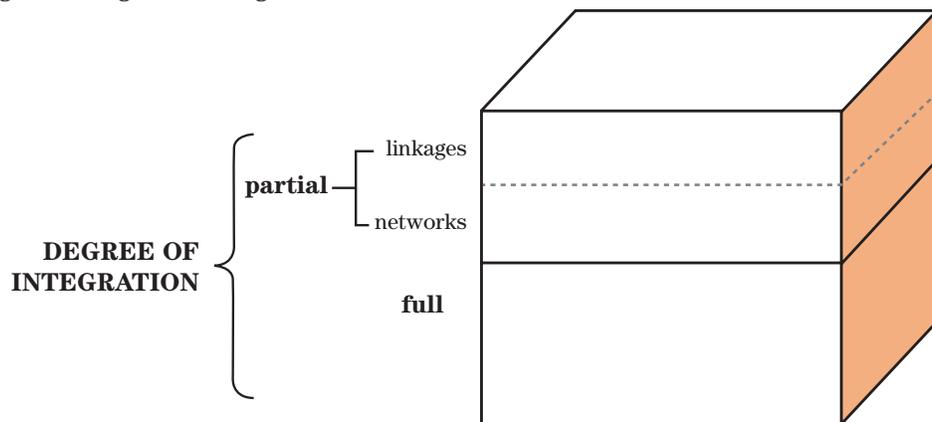
Tightness and looseness are used in the integration literature to describe relations among organizations and individuals. But this notion implies a unity to integration patterns that may or may not be necessary, but which is difficult to find. Along what single continuum are the multiple patterns, approaches, types, components, structures, processes and goals of integration to be placed? It is not clear that becoming tightly related or integrated in one respect necessarily results in becoming more tightly related in another

respect. A multi-hospital system fully integrated through common ownership or governance, for instance, is not necessarily integrated in the care it provides, even if this was one of the original objectives.¹¹ On the other hand, it might be possible to integrate service for specific clients through shared information among independent professionals, without requiring an integrated clinical team.

Khalil, a hospital discharge planner, creates a linkage on his own initiative with the manager of a shelter for men. On a regular and as-needed basis he phones the manager to refer clients, learn about hostel procedures and programs, and provide a vehicle for discussion if hostel staff have difficulty with his referrals. As a result of the linkage, protocols are developed for referrals to the shelter.

But Khalil’s workload increases, he feels he can no longer find time to talk with the hostel manager, and he relies on the written protocol to guide referrals. Months later the shelter changes its programs in ways that make many of Khalil’s referrals unsuitable – but Khalil doesn’t find out about this in advance and can’t influence the program change because the informal linkage has fallen apart.

Figure 8: Degree of Integration



Literature on integration uses a wide variety of terms to describe partial integration. Often terms will be used in different ways by different authors, but some terms tend to cluster at the looser or tighter ends of the spectrum of partial integration:

At the looser end, these terms are often used:

- collaboration;
- cooperation; and,
- linkage.

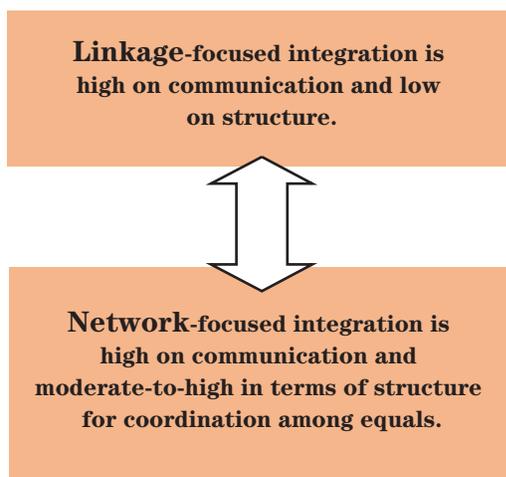
At the tighter end, these terms are often used:

- partnership;
- strategic alliance; and,
- network.

Instead of trying to reconcile a welter of often overlapping descriptive terms drawn from the literature, this module proposes two broad clusters within partial integration:

- linkage-focused integration – the looser version of partial integration involves less formal structures and processes; and,
- network-focused integration – the tighter version of partial integration, involving more formal structures and processes.

Figure 9: Linkages and Networks



Linkage-Focused Integration

Linkage-focused integration differs from network-focused integration because it involves less formal structures and processes. The different units and professionals understand who is responsible for each type of service, but there is no cost shifting between them and little or no loss of participants’ autonomy as a result of linkages.

Linkages can be used to generate several forms of joint activity, including:

- joint planning, including the development of guidelines, protocols and care pathways (described further below);
- joint problem-solving through collectively addressing new challenges, opportunities and threats; and,
- joint conflict resolution.

Its virtues are:

- its flexibility – it is an “as needed” method of integration, and it can easily be expanded to include stakeholders who might be reluctant to become involved in more formal kinds of integration (stakeholders from beyond the health system for example); and,
- a relatively low investment in infrastructure.

However, linkage-focused integration has disadvantages:

- it can be fragile, prone to fall apart if heavy workloads lead participants to hunker down and concentrate on immediate solo activities, or if tensions develop among those participating in the linkages; and,
- it can be difficult to monitor.

Linkage-based integration can be as simple as changing the way information is shared among participants in care. For instance, improvements in the quality of referral from physicians to hospitals have been observed when referral guidelines are disseminated with structured referral sheets that could be included in a referral letter. These sheets are checklists to be

completed at the time of referral, prompting the primary care physician about important elements of pre-referral investigation and management. However a potential for overload has been noted if general practitioners are expected to use referral sheets for a wide range of conditions. In the future, this might be addressed by advances in informatics (for example, on-line booking systems).¹²

Guidelines, protocols, care pathways and navigation are examples of linkage-based approaches to integration. These are described in the next two sections of this module.

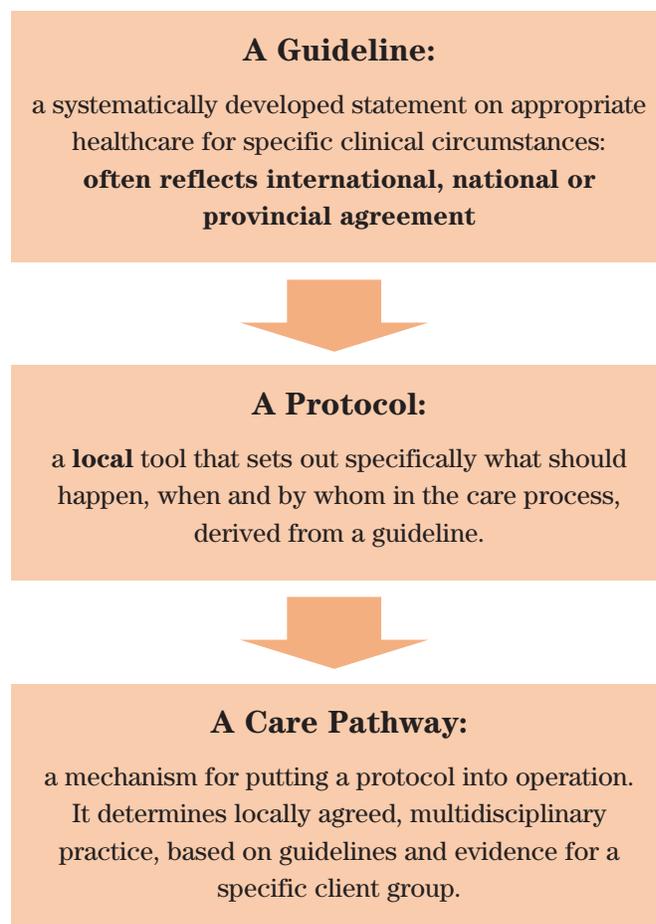
Guidelines, Protocols and Pathways as Forms of Linkage

Linkages among stakeholders can produce guidelines, protocols and care pathways as tools to integrate clinical service. As defined by the U.K.'s National Primary and Care Trust Development Programme:¹³

- **A guideline** is a systematically developed statement to assist practitioner and client decisions about appropriate healthcare for specific clinical circumstances.
- **A protocol** is a local tool that sets out specifically what should happen, when and by whom in the care process. It can be seen as the local definition of a particular care process, derived from a guideline. A protocol reflects local circumstances, and variation will occur because of differing types of local care provision.
- **A care pathway** is a roadmap for putting a protocol into operation. It determines locally agreed, multidisciplinary practice, based on guidelines and evidence (where available) for a specific client group. It forms all or part of the clinical record, it documents the care given, and facilitates the evaluation of outcomes for quality improvement purposes.

A care pathway (also called a critical path, care map, clinical pathway, integrated care pathway, collaborative plan of care, multidisciplinary action plan, care path and anticipated recovery path¹⁴) describes, for a specific

Figure 10: Guidelines, Protocols and Care Pathways



clinical condition, the typical tasks to be carried out, the timing and sequence of these tasks and the discipline involved in completing the task.

Despite movement towards multidisciplinary patient-focused care there is little evidence of record sharing across disciplines within these teams; the multidisciplinary integrated care pathway record is intended to facilitate this sharing and thus to promote teamwork in patient care.^{15, 16}

Standardized assessment tools and evidence-based collaborative care plans can promote integrated and coordinated palliative health service delivery, as demonstrated by the Palliative Care Integration Project in Southeastern Ontario, but critical to this was close attention to relationship-building in developing a team approach to delivering care.¹⁷

Navigation as a Form of Linkage

At the individual client level, clinical integration strategies can involve the provision of support to people as they try to find and access the services they need. Health service navigation involves activities to identify services needed by a client and to ensure task-level coordination among these services.

There are several versions of navigation:

- **Clients** can sometimes act as navigators on their own behalf, but they may need assistance in navigation (the equivalent of providing maps and compasses);
- **Family members** can sometimes act as navigators, but they may need assistance;
- **Existing direct service providers** (primary care physicians and nurses for example) can act as navigators for their clients, but they may need assistance in navigation; and,
- **Health care personnel who specialize in navigation** can take on the navigation function, on behalf of and in consultation with clients and families. Discharge planners and case managers are examples of these specialists. Workers in these roles promote open, honest, continuous and timely communication between health care professionals, service users and their families, to create coordinated care packages. ¹⁴

Case managers have been described as pivotal in coordinating the care of complex geriatric clients.¹⁸ In general, people with complex or multiple health problems and who need multiple services, provided concurrently or consecutively, are most in need of system navigation. Among elderly clients requiring community-based health care, community case co-ordination has been used to help them receive services and reduce or delay the use of acute care and long-term care. Case co-ordination typically involves assessment of client needs, care plan development and implementation, monitoring service provision and reassessment.

The range of navigators:

- **clients** (with or without assistance)
- **families** (with or without assistance)
- **direct service providers** (with or without assistance)
- **specialized navigators** (e.g. case managers, discharge planners)

A study sponsored by the Canadian Health Services Research Foundation led to the development of case co-ordination guidelines that specify ranges of co-ordination time and frequency of contact with elderly clients based on their risk of being placed in an institution. The authors stated that guidelines for case co-ordination may ensure consistency and quality of service delivery through a greater understanding of resources needed for case co-ordination, through education and training of new case coordinators, by establishing benchmarks to guide practice, and as a quality measure.¹⁹

Some system navigators limit their role to navigation within the health system. Other navigators carry out tasks related to a broader range of services. A full-service navigator, for instance, might also help a client to navigate into housing services, financial support services or transportation services if these non-health services are necessary because of a health problem.

Network-Focused Integration

Network-focused integration is more structured than linkage-focused integration, but it still operates largely through existing organizational units. Its aim is to coordinate different health services, to share clinical information and to manage the transition of clients between different units.

In the international literature a network is defined as formalized cooperation between independent organizations. Networks can incorporate a wide range of services, since looser structures attract a broader

range of organizations by letting these parties maintain more control over their own domains. Networks may serve one or more local districts^{5, 20, 21} and have formed at all geographic levels, from neighbourhood to nation, engaging a variety of participants.²²

It is important to distinguish between the terms “network” and “networking”. Networking commonly refers to people making connections with each other through a variety of informal means. Networks occur when links or connections among organizations or individuals become more formal (still less formal than full integration but more formal than the connections implied by networking).

The formalized cooperation at the heart of the definition of a network is achieved through structures that can include any or all of the following:

- written terms of reference to guide how the network will operate, that include the role of the network and the roles of network members;
- an identified core membership (i.e., individuals who are members or organizations that are members);
- a structure for the communication process among members (regularly scheduled meetings for instance);
- service agreements among members; and,
- a designated coordinator with power to suggest and advise but without full managerial power (i.e., without the power to enforce anything on network members).

A network is stronger if:

- its members have the power to commit their organizations to act in ways that promote integration and the power to ensure that commitments are fulfilled;
- it includes a process for evaluation of its performance; and,
- it has a distinct resource pool to allow it to operate its processes and structures.

Network-focused integration is high on communication and moderate-to-high in terms of structure for coordination among equals.

Networks with aims other than care coordination, specifically networks fostering knowledge transfer/exchange and innovation in health services, have recently gained prominence and require intentional development, processes and structures in order to flourish.^{23, 24}

Guidelines, protocols, care pathways and system navigation can fall within this form of partial integration if the creation or maintenance of these resources requires networks rather than linkages alone to support them.

A review of evidence from the Ontario Regional Stroke Strategy and the Ontario Dementia Care Networks Study²⁵ identifies seven strategies to advance the practice and research agendas related to network development and evaluation:²⁶

- developing a shared vision of care for particular groups of clients, products and services that goes beyond a single sector, such as acute care;
- identifying aspects of care that will most likely benefit from a network structure;
- embedding networks within broader strategies;
- developing both clinical and management leadership and collaboration at organizational and network levels;
- developing mechanisms to understand client flow and to identify gains that can be achieved through interactions of key service providers;
- using administrative and information mechanisms to increase efficiencies within networks; and,
- acknowledging that even within a centralized strategy variations will exist among similar networks.

Full Integration

Full integration implies that resources of different organizational units are pooled to create a new organization (the merging of parts into a working whole).²⁷ Full integration involves integrated governance and administration to integrate tasks, functions and resources in the planning and delivery of services.

International experience shows that mergers have been more common among similar organizations: for example, full integration of local home care companies yielding a new large company, or full integration of hospitals.

Full integration usually take place as a result of either of two processes:

- one organizational unit absorbs within itself one or more other organizational units, or
- two or more organizational units are joined to form an entirely new organizational unit.

“They were one man, not thirty. For as the one ship that held them all; though it was put together of all contrasting things – oak, and maple, and pine wood; iron, and pitch, and hemp – yet all these ran into each other in the one concrete hull, which shot on its way, both balanced and directed by the long central keel...”

Herman Melville, *Moby Dick*, 1851

The terms “merger”, “amalgamation”, and “acquisition” are often used to describe these two routes to full integration. However, literature on integration shows that the terms are often used interchangeably, or in contradictory ways (what one analyst calls a merger may be described by another analyst as an amalgamation or an acquisition).

Mixing Partial and Full Integration

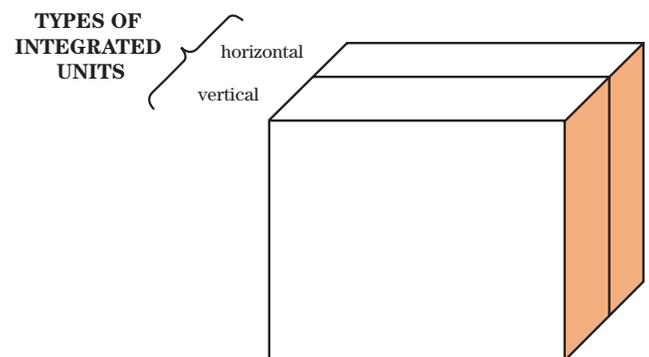
It is possible for a health organization to be a fully integrated organization and at the same time part of a network. An example of this is Toronto’s University Health Network (UHN). While called a network, it is the result of a merger (full integration) of three formerly independent hospitals.²⁸ However, the University Health Network has established network relationships (shared service contracts for example) with other organizations, and it chose the term “Network” to reflect its expectation that other hospitals as well as clinics and other services would affiliate with UHN.²⁹

2.3 Second Dimension in the Matrix: Types of Integrated Units

Two major types of integration described in the literature are:

- horizontal integration; and,
- vertical integration.

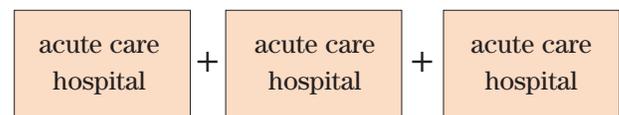
Figure 11: Types of Integrated Units



Horizontal Integration

Horizontal integration refers to integration of organizations or units that are at the same stage of service delivery. The most common examples of horizontal integration involve hospitals that have consolidated, shared services, or merged.⁵

Figure 12: An Example of Horizontal Integration



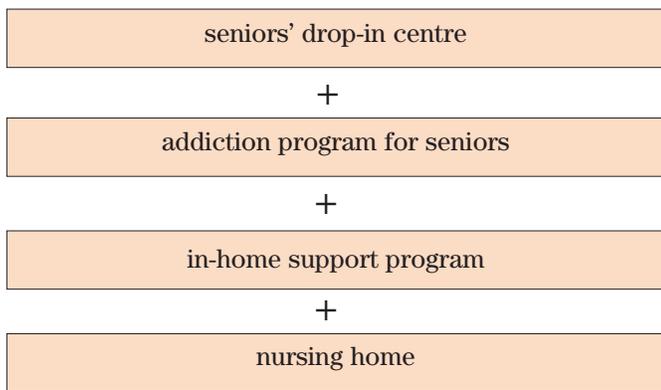
Vertical Integration

Vertical integration refers to integration of *different* inter-related or inter-dependent health sector elements on the continuum of care (see Appendix A).

If one thinks of primary care as care provided by a generalist in a community setting, and secondary care as care provided by a specialist in hospital, then health care services that exhibit a mix of primary and secondary care attributes show some vertical integration.³⁰ While regional health authorities in Canada vary in the number

and type of services included within their mandates, they commonly include funding responsibility for a vertical range of services, from hospitals to community and long-term care, and sometimes including public health and health promotion. They typically are only partly vertically integrated, however, given the absence of responsibility for physician services, pharmaceuticals and cancer care.³¹

Figure 13: An Example of Vertical Integration



While the effects of horizontal integration in the 1980s and '90s continue to play themselves out,³² vertical integration is the emphasis of the most recent wave of health reform and is inherent in many integration definitions.^{33, 34} Vertical integration may entail integration across primary, secondary, and tertiary care.

2.4 Third Dimension in the Matrix: Components of Integration

The nuts and bolts of integration are the relationships and activities occurring within tightly or loosely, horizontally or vertically integrated entities.

Integration can involve three components:

- integration of clinical activities;
- integration of support activities; and,
- integration of values and norms.

Integrating Clinical Activities

Integration of clinical activities is concerned with the extent to which client care is integrated across the clinical functions, activities, services and operating units of a system. Clinical integration can take into

account service needs between different periods of care (pre- and post-hospitalization for example) and services provided within a period of care (community service and housing support for instance).

Within integration of clinical activities, three variations can be identified:

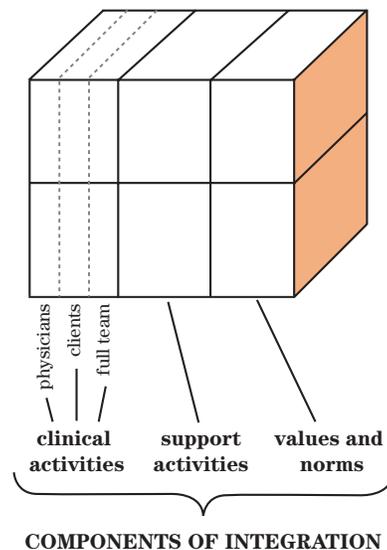
- integration of physician activities;
- integration of the full clinical team; and,
- integration of clients.

Integrating Physician Activities

Physician integration is often addressed as a special form of clinical integration because of the traditional role of physicians as gatekeepers to other parts of the care system, but also because they are usually outside the funding envelope of regional planning and funding organizations across Canada.

Physician integration has to do with the extent to which physicians integrate their activities with those of other physicians – in particular, integration of the efforts of primary care physicians with the activities of specialists. However, issues of integrating physicians into a broader team can also be considered part of physician integration. This dimension is

Figure 14: Components of Integration



particularly important given the current emphasis on multidisciplinary primary care that involves the integration of physician activities with the activities of registered nurses, nurse practitioners and many other health professionals.

In community care networks, family physicians have had relatively little formal involvement in integration activities. Research on community-based dementia care networks, for example, found that involvement of family physicians in network operations was discouraged by the fee-for-service payment system. Under this system family physicians were, in effect, penalized if they left their practices to attend network meetings or attend case conferences for clients with complex care issues.²⁵

How physicians are remunerated is a core strategy of health care reform proposals around the world. Each model of payment generates its own incentives with respect to how providers produce health services, how efficiently and equitably services are provided, the quality of care and how intensively health services are used by patients.³⁵ The payment model also influences the degree to which physicians integrate their activities with each other and with other health resources. In short, if they are paid to engage in integrative activities, they are more likely to pursue these activities.

There is evidence that financial strategies can encourage or discourage physician integration. For example, successful implementation of integrated primary care in Taber Alberta was facilitated by an alternative payment plan (APP) for physicians. APPs generally provide an alternative to fee-for-service funding, remunerating physicians proactively for provision of a specified range of services to a target population.³⁶

Another example of the power of financial incentives are alternative payment plans such as the plan implemented at the Southeastern Ontario Health Sciences Centre, Kingston, in this case called an Alternative Funding Plan (AFP). Global funding was obtained from the Ontario Ministry of Health and Long-Term Care for all clinical services provided by the

Centre. At the departmental level, fee-for-service payment for full-time clinical faculty members was replaced with a negotiated rate of remuneration for each member. Members reported spending more time on patient care after referral or hospital stay and spending more time coordinating community care after a hospital stay, suggesting that the AFP helped physicians to play a larger service integration role.³⁷

Family Health Teams (FHTs) in Ontario are intended to provide integrated comprehensive primary care. All of the funding models for physicians in FHTs are alternatives to fee-for-service, involving a form of blended compensation that may include salary, capitation, incentive and complement payments in varying degrees.³⁸

Some efforts in Ontario to foster new integrated relationships between physicians and hospitals have created special physician task groups, apart from the Medical Advisory Committee and the Medical Staff Association, to advise the institution on broader issues surrounding medical staff organization, involvement in the organizational structure and other health system changes.³⁹

Many opportunities have been suggested for Family Health Teams and hospitals to work together, including:

- coordinating after-hours service and emergency department coverage;
- coordinating programs such as chronic disease prevention and management, palliative care, rehabilitation and mental health; and,
- using information technology to allow FHTs and hospitals to communicate effectively.⁴⁰

Integrating the Clinical Team

Integration of the full clinical team addresses the extent to which members of a number of clinical professions are economically linked to a system, use its facilities and services, and actively participate in its service delivery, planning, management and governance. It involves the creation and management of multidisciplinary teams appropriate to the clinical situation by mechanisms that mobilize the skills and coordinate the expertise of team members, while allowing each member to exercise professional judgement.

“I and Pangur Ban my cat,
‘Tis a like task we are at:
Hunting mice is his delight,
Hunting words I sit all night.

So in peace our task we ply,
Pangur Ban my cat and I;
In our arts we find our bliss,
I have mine and he has his.”

Written by a ninth century Irish monk
at the monastery of Saint Gall

Inter-professional teamwork is considered to be an essential dimension of integration to improve the effectiveness of health services, and the formation and maintenance of clinical teams is one of the major responsibilities of organizational structures within health care.⁴¹

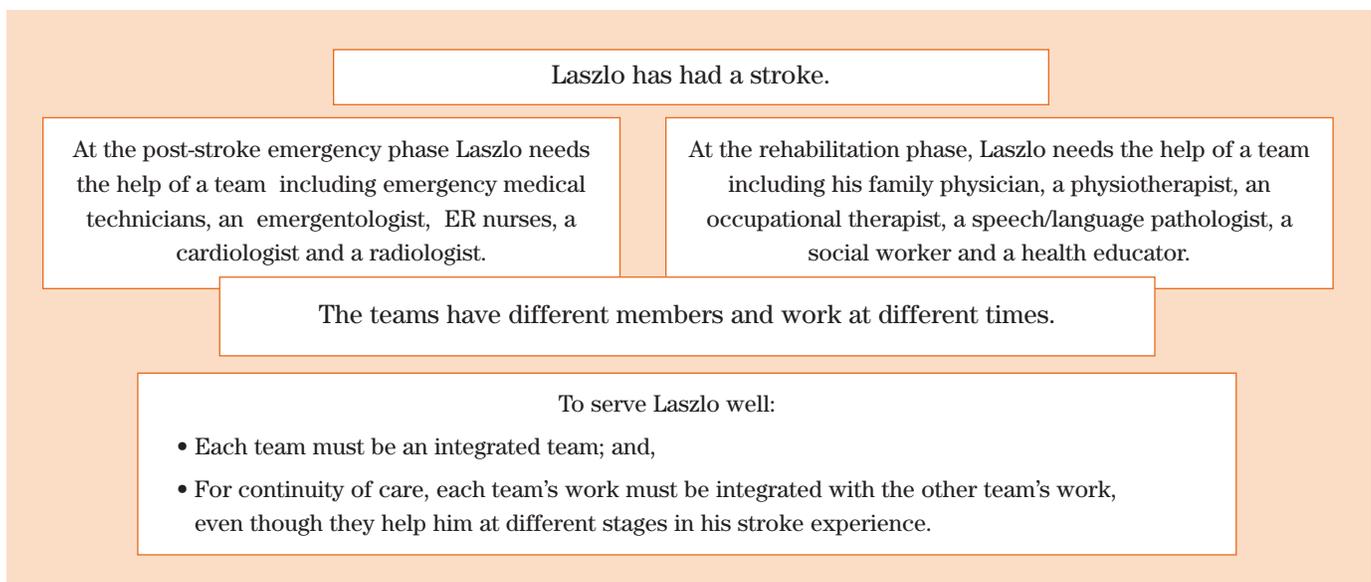
Integrating members of different self-regulated health professions into teams poses a number of challenges, largely because each profession (through its regulatory college) establishes the scope of practice for the profession’s members. While health professions generally value and promote teamwork as part of professional practice, the terms of serving on an integrated team cannot violate a profession’s scope of practice.

Clinical team integration itself can be described by degrees (outlined in Appendix B).

There is evidence to suggest that individuals with chronic complex, severe and/or unstable needs would require a larger, tightly integrated clinical team.⁴²

While the increasingly complex health problems addressed by health professionals are creating more interdependencies among them, there is still limited understanding of the complexity of inter-professional relationships.⁴³

Figure 15: Integrating the Clinical Team



Empirical literature on professional teamwork has not generally shown evidence of great success and there has been widespread academic skepticism about the way in which inter-professional integration has been undertaken.⁴⁴ However, examples exist of successful multi-disciplinary care initiatives in which a team framework enabled different types of professionals to discuss referrals and to negotiate the division of labour, which enhanced information flow and avoided duplication of effort. A review of the literature on successful inter-professional collaboration found it to be essentially an interpersonal process requiring the presence of several elements in the relationships among the professionals in a team:

- a willingness to collaborate;
- trust in each other;
- mutual respect; and,
- effective, ongoing communication.

Research also suggests that for teamwork to succeed, a clear and recognizable idea or goal must serve as the focus for team members;⁴⁵ integration of values and

“So, let us not be blind to our differences, but let us also direct attention to our common interests and to the means by which those differences can be resolved.”

John F. Kennedy, Commencement Address at American University, Washington D.C., June 10, 1963

norms helps produce successful team-based integrated service delivery.

Researchers have also concluded that some features of teams generate strain and impede team development. They include:

- heterogeneity of team composition;
- role conflict and role overload;
- constraints placed on members by the larger organizational structure; and,
- members’ lack of knowledge about the process of team development.

Table 2: Disablers and Enablers for Team Development

Things that make it challenging to develop and sustain a team:

- diversity of team composition;
- role conflict;
- role overload;
- constraints placed on members by the larger organizational structure; and,
- members’ lack of knowledge about the team development process.

Things that help in developing and sustaining a team:

- | | |
|--|--|
| • a willingness to collaborate; | • co-location of staff; |
| • trust in each other; | • shared training; |
| • mutual respect; | • good liaison processes and structures; |
| • communication; | • stable conditions of employment; and, |
| • a clear and recognizable idea or goal; | • flexibility in working arrangements. |
| • shared values and vision; | |
| • single line management arrangements for operational issues and clinical supervision; | |

The initiatives that have been analyzed show the importance of concrete processes and structures in the development and operation of collaboration.^{46, 47} The following processes and structures seem to contribute to effective interdisciplinary work:

- co-location of staff;
- shared training;
- single line management arrangements that provide for both operational issues (clear goals and clear accountabilities for instance) and clinical supervision;
- good liaison processes and structures;
- stable conditions of employment; and,
- flexibility in working arrangements.¹⁴

Integrating Clients as Team Members

Integration of clients into the clinical practice team is relatively new, but client involvement in decision-making is now widely regarded as a feature of good quality health care,⁴⁸ although the language of shared decision-making appears to refer to medical care as the locus of client involvement.⁴⁹ Client-centred and person-centred practice are terms used among other health care professionals that subsume shared decision-making but incorporate broader concepts of power sharing between the client and the professional.^{50, 51}

A common form of client integration is shared clinical decision-making in which clients and their health care providers form a partnership with joint responsibility for decisions about tests, medications, procedures, referrals or behaviors. The need for client-provider partnership is most compelling when:

- clients have a serious or life threatening illness;
- different treatment options exist with different benefits and risks; and,
- outcomes are uncertain.⁵²

It is equally important in self-care and chronic disease management involving many daily lifestyle changes.⁵³ Chronic disease management models are based in part on client self-management, although self-management is not an entirely accurate term, since clients are generally

expected to manage their own care in partnership with health professionals. As Edward H. Wagner MD put it in his description of the successful Wagner-McColl chronic disease management model:

“Patient-provider interactions resulting in care that improves outcomes are found in health systems that... assure behaviourally sophisticated self-management support that gives priority to increasing patients’ confidence and skills so that they can be the ultimate manager of their illness.”⁵⁴

Integrating clients into an organization may require a high level of commitment and major adjustment to organizational processes and structures, in part because client integration is a break with tradition. Throughout most of the history of organized health services, clients have been seen largely as passive recipients of service rather than active partners in their care.

Client integration into the health care team has not been widely discussed in the literature on inter-professional integration. Client-provider relationships may be core to continuity of care, but they can be paternalistic rather than a partnership among equals.^{3, 43, 52} Client integration has been included in concepts of clinical integration, for example, only to the extent that the client is the “ultimate customer” of clinical services,^{5, 20} but a more proactive or participatory client role may be warranted to integrate clients and families in clinical decision-making.⁵⁵

Integrating Support Activities

Integration of support activities can be divided into two clusters:

- integrating the activities of governors (i.e. members of governing boards) and managers. These activities are considered “support” activities because they are meant to support the service delivery role of health care organizations; and,
- integrating activities related to supplies, technologies (including information technologies) and specialized support personnel (including resources such as marketing, human resource management and evaluation).

Integrating the Activities of Governors and Managers

These are considered a separate cluster because governors and managers are vested with formalized authority in their organization. Integration of the activities of managers and governors is generally more challenging because it holds the promise or threat (depending on one's point of view) of altering the arrangements of formalized authority within and among organizations. Integration of the activities of governors and managers should not lead to the elimination or blurring of the distinct roles of governors or managers. Rather, it involves coordination of these distinct roles.

Integration of governance and management has been considered a building block for clinical integration,⁵ and much attention has been paid to managerial and structural factors affecting administrative integration in collaborative organizations, evidenced by the relative number of indicators of integration of support activities compared to other substantive aspects of integration (as outlined in Appendix C).

In addition to how governance and management can each be integrated, attention needs to be given to whether – and how – governance and management should be integrated with each other, and how both can be integrated with clinical functions. Bridging the gap between administration and clinical service is a challenge in most health care settings, and dedicated financial resources and human resources can help.²⁵

Integrating Supplies, Technologies and Specialized Support Personnel

This includes integrated activities related to acquisition, maintenance and use of supplies, technologies (including information technologies) and specialized support personnel (including resources such as marketing, human resource management and evaluation).

Much attention is being given in Ontario and elsewhere to back office integration – usually defined in terms of activities related to supplies, technologies and specialized support personnel. This component may increasingly be seen as an area for integration in Ontario because it may create efficiencies and cost-savings that can act as fuel for reinvestment in the clinical components of organizations.

Example: Partial Integration of Governance and Management

Each of the boards of four mental health agencies approves and oversees the mission statements and strategic plans within its agency. Each board has a strategic planning committee, but all eight board and committee Chairs have never met to compare and harmonize their plans. They create a network among themselves to pursue harmonization, but soon realize that the Executive Directors of the agencies should join the network, allowing governance and management of efforts aimed at integrated planning.

The network succeeds, but after a year it realizes that its efforts would be stronger if the Chairs and Executive Directors of the two local addiction service agencies also joined. They extend the invitation, which is accepted. The expanded network (which meets four times a year) then decides to invite the Chair and Medical Officer of Health from the local health unit to join two of the meetings each year, since many addiction and mental health clients face problems that can best be addressed through public health programs.

In short, participants have created partial integration (using a network focus) horizontally and vertically, addressing key governance and management activity related to strategic planning.

Integrated information systems appear to be essential to all other strategies, and adoption of health information technology is widely supported in the health care sector.⁵⁶ The Health Services Restructuring Commission (HSRC) in Ontario identified a comprehensive health information management system as the fundamental enabler of all other health system coordination and integration.⁵⁷

The more advanced parts of Kaiser Permanente (the largest non-profit healthcare system in the US) have introduced sophisticated information technology (IT) systems that reduce administrative time, particularly clinicians' time spent taking medical histories, dictating

letters and locating patient records.⁵⁸ Other studies point out that integrated information systems are a way to foster continued cooperation within care networks and are the key to clinical efficiency.⁵⁹ Shared data also offer agencies opportunities to benchmark themselves against others.⁶⁰

But IT infrastructure has not always lived up to its promise. There is evidence that the use of IT in key clinical functions remains low, even among supposedly integrated health care delivery organizations: many organizations do not have IT systems that provide clinical information or support clinical decision-making.⁶¹ A common problem among integrated health networks in the US has been an inability to provide enough capital investment and trained personnel for IT to provide a seamless flow of information throughout the network.²² Even in Kaiser Permanente, introduction of an electronic medical record system created challenges;

- many users felt the selection of the system was detached from the local environment;
- problems with software development increased local resistance; and,
- clinicians initially experienced reduced productivity.

Learnings from the broader literature on communication and information systems include:

- the importance of one-stop information gathering;
- the need to integrate financial information systems with clinical information systems;
- the need for information and management systems to be accessible and usable;
- the need for informational linking and sharing across agencies, across disciplines, across the care continuum and across care sectors;¹⁴
- the benefit of involving targeted users early on in the adoption and implementation process;
- the advantages of rigorously pilot testing new systems;
- the need to plan for the technical and human transition from older systems; and,
- the need to allocate adequate resources for ongoing training, support, and maintenance.

Integrating Values and Norms

Proponents of integration can mandate process and structures to achieve integration. What they cannot mandate, however, is:

- what people value;
- what standards (norms) of behaviour they espouse based on these values; and,
- what behaviours they will exhibit based on their values and norms.

Proponents of integration can influence values, norms and behaviours even though they cannot mandate them – and influencing them is often crucial to successful integration. Influencing values, norms and ensuing behaviours often makes the difference between “on paper” integration (in which people are supposed to behave in an integrated way but do not), and actual integration (in which people, motivated by similar or compatible values and norms, behave in an integrated way).

Two clusters of values and norms are important for integration:

- *Values and norms related to integration itself.* For instance, if potential participants in an integration endeavor value autonomy and solo activity more than they value interdependence and joint activity, integration will be challenging. Values and norms that support integration must be cultivated – for instance, by fostering an organizational culture that respects other caregivers and organizations and institutionalizes collaborative values and norms in policies, procedures and incentive systems.⁶²
- *Values and norms related to the tasks and services to be integrated.* For instance, two programs that provide services for people with substance abuse issues may be under consideration for integration, but if staff in the programs have radically different concepts of what causes addiction, what values should be embedded in treatment and what activities comprise treatment, integrating the programs may be difficult.

A *value* is something we consider good or bad, without recourse to empirical proof that it is good or bad. For instance, helping people who are in need, through no fault of their own, is a *value*.

A *norm* is a rule or standard of behaviour, meant to express how people should behave in accordance with accepted values. For instance, calling 911 when one encounters a person who may be having a heart attack is a *norm*.

Processes and structures to create integration do not guarantee integration:⁴⁴ changes in values and norms (which together comprise cultural change) must be developed to support integration.⁶³ In the context of partial integration between hospitals and community organizations, it has been argued that most integration is not so much between organizations per se as they are collaborations between like-minded people, and that relational practices must be acknowledged and supported institutionally for partial integration to succeed.⁶⁴

Successful integration appears to require a shared culture, particularly in terms of full integration.^{65, 66} Strategies addressing cultural change can involve:

- recognizing and developing leadership committed to collaboration;
- determining the unique assets (e.g., culture, language, skills, connections) of each member and creating settings where these talents are used;
- assessing and reducing participation costs;
- developing shared goals;
- identifying common needs and shared concerns;
- creating plans that articulate strategies and responsibilities for accomplishing collaborative goals, monitoring progress toward these goals, and periodically reviewing and revising them;
- creating norms about participation;
- creating inclusive decision-making; and,
- formalizing roles and processes.⁶⁷

Partial integration also involves many critical success factors that involve changes in values and norms (see Appendix C).⁶⁸

Integrating values and norms involves a wide range of strategies and techniques. While it is beyond the scope of this module to provide details on these strategies and techniques, the reader will find a substantial body of change management literature and experience that can help with integration of values and norms.

However, two elements related to values and norms are worth further attention in this module and are discussed below:

- trust as a key value; and,
- intellectual, ethical and behavioural commitment.

Trust as a Key Value

Research into factors that support partnership concludes that strong mutual trust characterizes successful partnerships.⁶⁹ Trust can be engendered by sharing rather than hoarding knowledge, for example, and ensuring that smaller partners are recognized for bringing value to the integration through resources such as local knowledge and legitimacy. Developing a common vision among partners is consistently identified as essential to success and is related to trusting relationships: trust helps partners to develop a common vision, and this helps build trust.⁶⁹ A facilitative management style that builds relationships and gains trust has been recommended for achieving sustained change in the culture of organizations.⁷⁰

“Culture is an overarching mechanism in an organization which constrains all other aspects of organizational life and limits what is considered desirable, possible and practical to do.”

Heather Smith and James McKeen,
Instilling a Knowledge-Sharing Culture,
Queen’s Centre for Knowledge-Based Enterprises,
Queen’s University, May 2003

“Issues of *incentives, motivations, and emotions* are usually of much more concern in human systems than in other kinds of systems. In computer programs, for example, the ‘incentives’ of a program module are usually easy to describe and completely controlled by a programmer. In human systems, on the other hand, the motivations, incentives, and emotions of people are often extremely complex, and understanding them is usually an important part of coordination. Even in human systems, however, analogies with other kinds of systems may help us understand fundamental constraints on coordination and imagine new kinds of organizations that might be especially motivational for people.”

The Interdisciplinary Study of Coordination,
Thomas Malone and Kevin Crowson, 1993

“All organizational cultures tend to vary along two dimensions: sociability and solidarity...”

- *Sociability* refers to the emotional and non-instrumental relations which exist within an organization, i.e., the friendliness among members of a community. Sociability makes work enjoyable, fosters teamwork, promotes information sharing, and creates an openness to new ideas.
- *Solidarity* refers to the degree to which members of an organization share goals and tasks. It makes it easy for them to pursue shared objectives quickly and effectively, regardless of personal ties and generates strategic focus, swift response and a strong sense of trust.”

Heather Smith and James McKeen,
Instilling a Knowledge-Sharing Culture,
Queen’s Centre for Knowledge-Based Enterprises,
Queen’s University, May 2003

Intellectual, Ethical and Behavioural Commitment

A frustration common to integration initiatives is the difference between what people believe, and how they act.

It is not unusual for instance, for people to support integration because they believe it is the logical or ethical way to operate – yet they may continue to act as if building empires is more important than building bridges. Two factors may account for much of this discrepancy between belief and behaviour:

- **The force of habit.** Since behaviour is shaped not only by belief, but also by repeated past behaviour, it is not surprising that some stakeholders will continue to behave for a while the way they have behaved in the past, despite intellectual or ethical commitment to new, more integration-focused ways of acting; and,
- **Skepticism about new incentive systems.** Since people usually behave in response to incentives and disincentives, it makes sense that they will behave in integration-focused ways if incentives and disincentives move them in that direction. However, new incentive systems are often met with a degree of skepticism. This may not be because people disagree with new incentives. In fact, they may embrace them both ethically and intellectually. However, they may not believe that those who control the levers of incentives are actually serious about changing the incentives. Under these circumstances people will often continue to act in accordance with the former incentive system, since it is at least a known quantity.

Dealing with both force of habit and skepticism about new incentive systems can involve several strategies:

- **Avoiding blame.** It is easy to assume that people whose stated beliefs and overt behaviours are mismatched must be behaving in bad faith. However, bad faith may have nothing to do with it. They may simply be struggling to make sense out of the discordance between past and future habits and reward systems;

- **Discussing the need for behavioural change.** It is important that integration stakeholders take time to discuss the specifics of desirable integration-focused ways of acting and to discuss the details of new incentive systems. Such discussion can make the issues explicit, concrete and manageable rather than implicit, theoretical and unmanageable; and,
- **Setting the example.** Those who take on leadership roles in integration initiatives must be sure their own behaviors match their belief in integration. For instance, this may involve developing an understanding of, and tolerance for, webs of multiple and joint accountabilities in an integrated system, rather than the tidier but unconnected accountabilities that characterize less integrated service arrays.

2.5 Using the Matrix

The matrix described above can be used for three purposes:

1. **to inventory what kinds of integration are already in place** in an organization or a group of organizations;
2. **to plan further integration**, benefiting from greater clarity in identifying the desired types, degrees and components of integration; and,
3. **to monitor and evaluate integration initiatives** in terms of whether they achieve their ultimate goals and whether integration itself, as an intermediate goal, has been achieved. This will be similar to any monitoring and evaluation exercise, but will also require integration-specific items such as measures of inter-organizational and inter-professional collaboration and measures of the degree to which the purposes of the integration are supported by stakeholders.⁶²

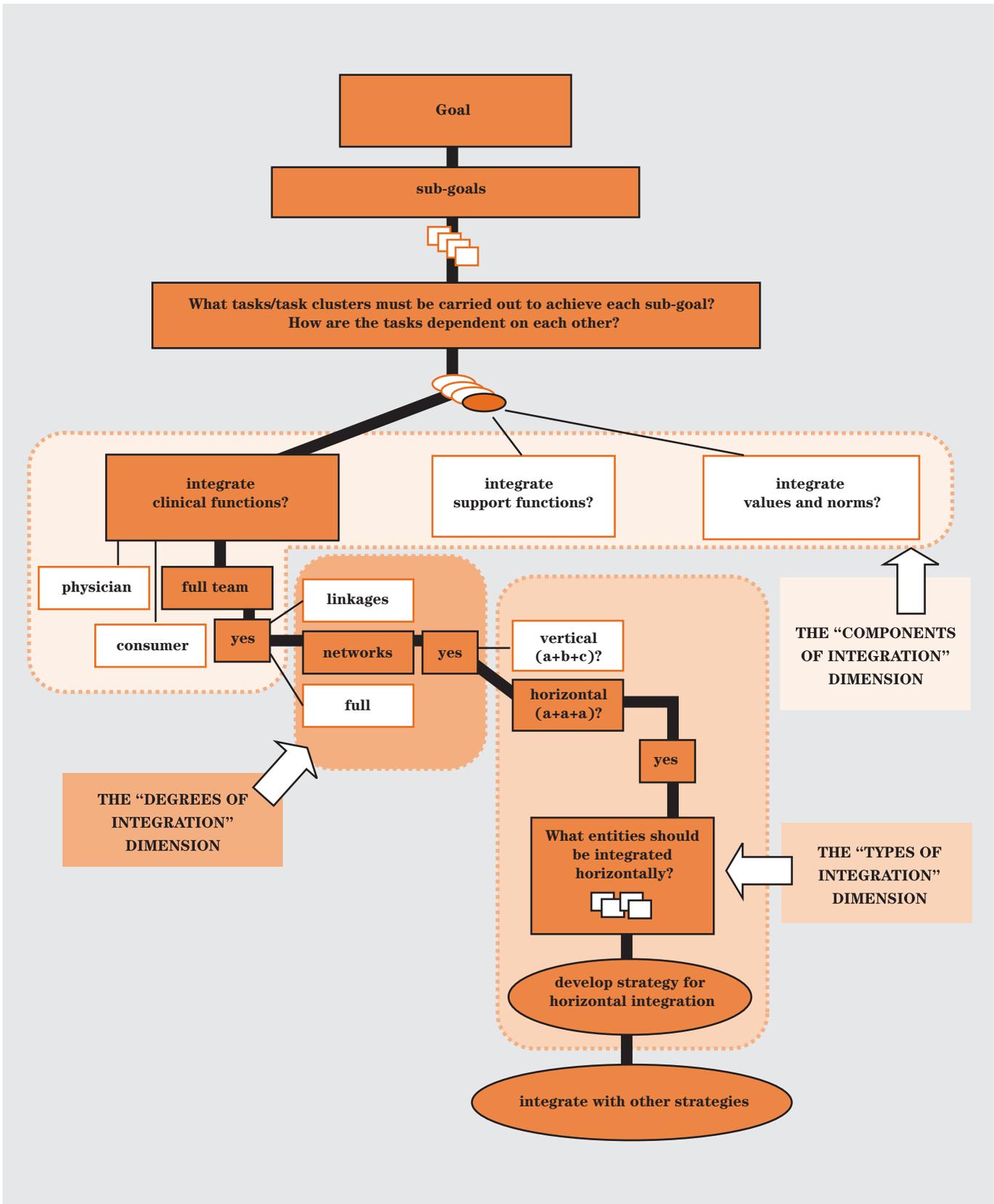
Figure 16 provides a “thinking path” that can be used for those wanting to make decisions about integrative tactics and strategies, driven by the goals of an organization but also driven by pragmatic tasks and task clusters that any organization must perform to achieve its goals. Analyzing these tasks and the dependencies among them will help ensure that integration does not become an integrated shell surrounding an un-integrated core.

In this thinking path, a number of questions and answers flow from the initial question: “What are/should be our clinical group’s goals?” The path in Figure 16 follows only one of the many branching paths, arriving at the final conclusion. This branch path is shown by thick lines connecting shaded boxes.

The last activity shown on the thinking path is integration of the results of all the branching paths.

A more detailed version of this thinking path is included as Appendix D.

Figure 16: A Thinking Path for Integration Initiatives



Influences on Integration

Four other factors affect integration (shown in Figure 17):

1. the drivers of integration (external drivers or internal drivers);
2. the size of integration (the number of units integrated or the size of the units integrated);
3. the range of stakeholders involved in the integration; and,
4. previous integration experience.

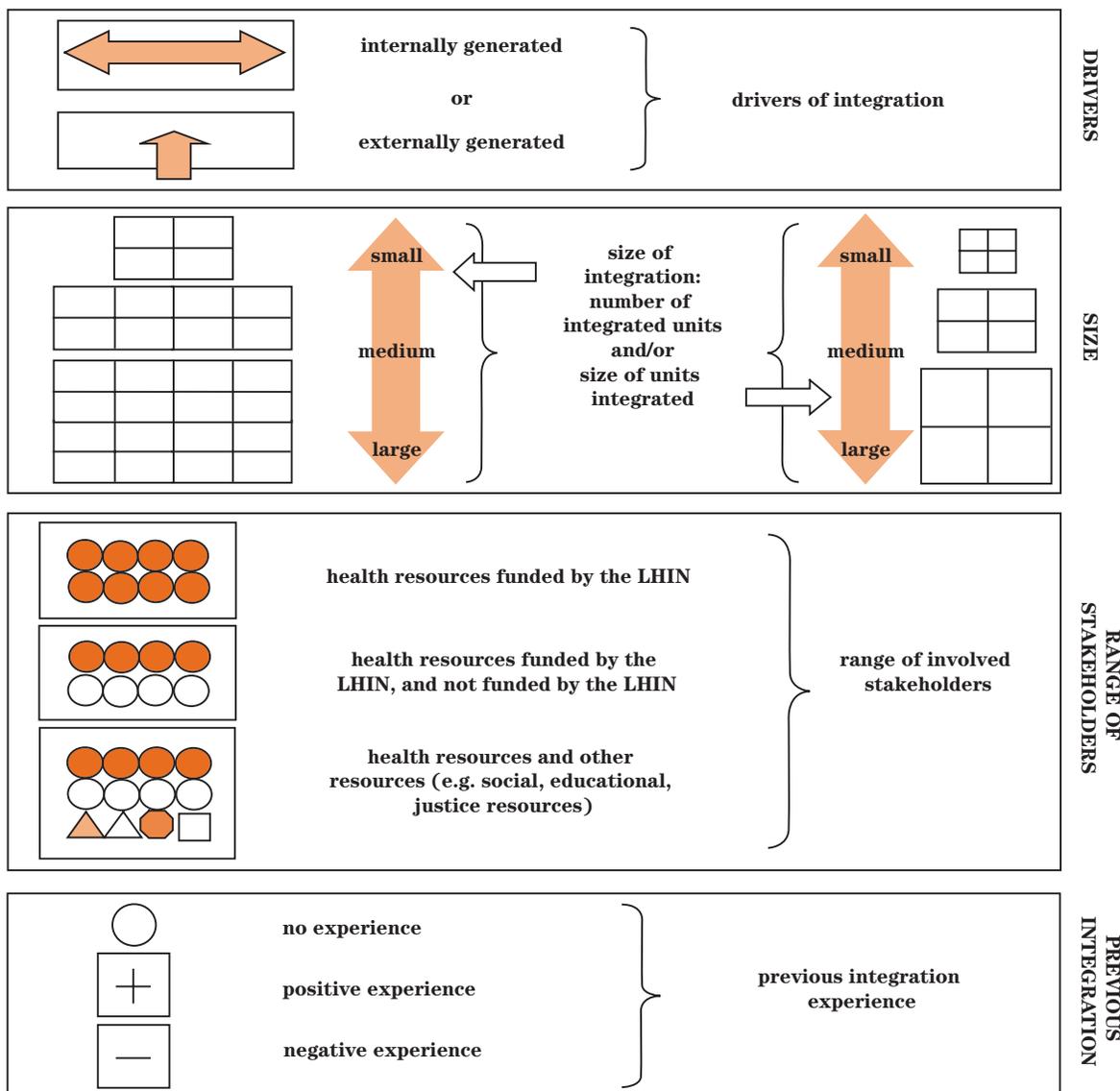
3.1 The Drivers of Integration

Integration can occur in response to pressures from the external environment or from internal factors, although the two are not independent.³⁴

External Initiation

External initiation refers to integration that is driven by market forces (a common US driver) or by government decree (common in most other countries).

Figure 17: Other Influences on Integration



Under external initiation, integration tends to be more extensive and formal in terms of combined processes and structures. It may involve more comprehensive strategies to bring components together into what are often called integrated health organizations. Such institutionalized integration may result in full integration of formerly independent organizations.

Internal Initiation

Internal initiation refers to integration that is driven voluntarily by collaborating members of the organizations involved.

Ontario’s LHINs can build on voluntary integration already occurring in their areas, so it is important to know the conditions for voluntary success. For example, the motivations of individual health-care professionals will be important determinants of voluntary integration – and motivations that favour cooperation will likely arise and survive if there is already a degree of integration of values and norms among the people who will shape the voluntary integration and whose activities are meant to be integrated. The voluntary approach can often create linkages bringing together discrete tasks, programs or services without creating new or tight organizational structures. Such voluntary efforts among independent

entities can lead to integrated service delivery without a central organization, authority, governance or funding. Apart from the specific coordinated activity, each participant may remain fully independent.

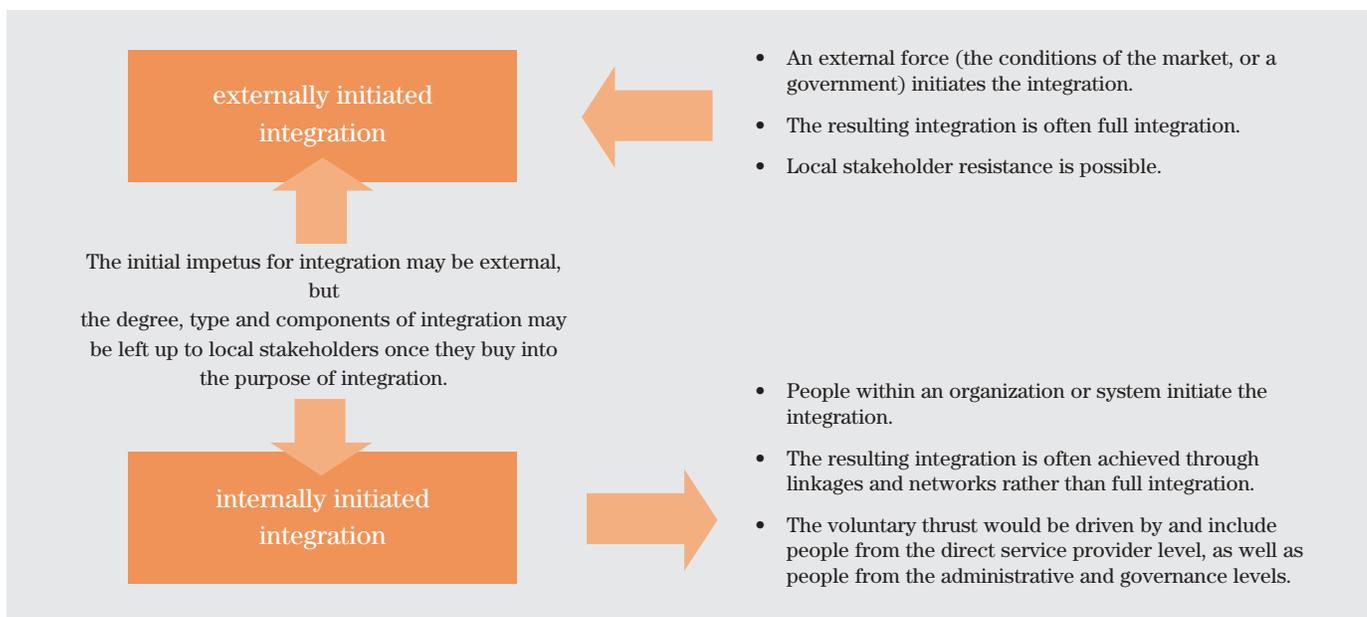
Voluntary initiatives tend to take place at a clinical or program level of integration, through collaboration on interrelated tasks.

External initiation and internal initiation are not completely separate. For instance, the decision that integration will take place may be externally initiated by a government or a local health authority, but the specific form of the integration may be a decision delegated to local stakeholders (so the form becomes internally initiated).

Ontario’s Local Health System Integration Act, 2006, provides for both external and internal integration – and suggests a relationship between the two – by stating that:

“Each local health integration network and each health service provider shall separately and in conjunction with each other identify opportunities to integrate the services of the local health system to provide appropriate, co-ordinated, effective and efficient services 2006, c. 4, s. 24.”

Figure 18: External and Internal Initiation



However for external and internal initiators to work together in this way, internal initiators must be persuaded to buy into the purpose of the integration. Without buy-in, internal stakeholders may opt for the least intense forms of integration or they may pursue a goal for integration that is at variance with the goal put forward by the external initiator.

3.2 The Size of Integration

The size of the integration activity, within or among small organizations or large, involving few or many organizational units across large or small geographic areas, will affect the logistics of integration. Large sizes may require other supporting factors to ensure success – extra time for instance, enhanced resources to effect the integration, or greater variety in the ways organizational units are integrated. Related to size are the organizational boundaries of integration, whether intra-organizational or inter-organizational. Larger challenges might be expected with a larger number of stakeholders, but the gains from overcoming these challenges may also be larger.

A common rationale for integration is that it reduces transaction and production costs. Savings in production costs in particular are thought to arise from achieving economies of scale and scope. Size, therefore, is a consideration that influences integration activities, as economies of scale accrue when larger organizations have lower average costs than smaller ones. Economies of scope arise if the joint delivery of a range of health care services by one provider is less costly than their combined delivery by separate providers. It might be expected, then, that integration would tend toward larger and larger integrated units. Studies of integrated primary care organizations (IPCOs), however, have generally been unable to find a relationship between the size of the IPCO (as measured by the number of patients or practitioners) and costs. This may be because size can have contradictory cost influences:

- On the one hand the presence of economies of scale would suggest that average costs fall as the organization grows; but,
- On the other hand coordination costs are likely to rise as the number of organizational actors increases.⁷¹

3.3 The Range of Involved Stakeholders

Related to but distinct from size is the range of public and private sector stakeholders involved in integration. The range of integrated resources can include:

- **Services that fall under the funding mandate of LHINs.** These services comprise a wide range of potential health service integration partners, but do not include public health and primary care (with the exception of community health centres, which lie under the LHIN mandate);
- **Services that do not fall under the LHIN funding mandate but that fall under the regulatory and funding mandates of the Ministry of Health and Long-Term Care** (including public health and primary care);
- **Services funded or regulated by other ministries.** These services may not be health services;
- **Services funded or regulated primarily by other levels of government** (federally regulated and funded services for Aboriginal people and First Nations people for instance); and,
- **Civic resources that receive little or no funding from any level of government.** For example, these may be charities that provide services through volunteers or paid staff.

Some definitions of integration reach beyond health services by characterizing integration as the search to connect the health care system with the social services system, for the purpose of improving outcomes.⁴² These connections are sometimes referred to as intersectoral integration, often in relation to collaboration between health ministries and other government ministries and agencies, particularly when addressing social and other determinants of health.⁷² For instance, Browne *et al* describe an integration model applied to services for families and young children that identifies eight sectors to be integrated: health, social services, education, housing, childcare, recreation, labour, and correctional/custody services.⁷³

A broad determinants of health perspective suggests that intersectoral integration is desirable, especially for vulnerable or marginalized populations who require attention to broader living conditions.⁷⁴ However, administrative and cultural differences among sectors mean that intersectoral integration may only be achievable through linkage-based or network-based integration rather than through full integration.

With a range of stakeholders will also come a range of capacities and power. A government agency that sets up an interorganizational arrangement, and a community group that is invited to sit at the table, differ in these respects. Astute community groups can be as powerful as representatives of organizations with more traditional power bases, but the differences must be recognized.

In short, even the simple logistics of integration will be complicated by the number, type and capacity of stakeholders, requiring close attention to managing relations and processes among them. Module 5 in this toolkit series (*Community Engagement and Communication*) addresses some of the complexities of involving multiple stakeholders.

3.4 Previous Integration Initiatives

The degree to which an integration initiative will succeed may depend in part on the track record of integration in the community. Initiatives operate within very specific, localized contexts and are strongly dependent on the history of past relationships between the organizations involved and local requirements and circumstances.⁶⁹

Previous integration efforts in the community that failed to achieve their goals or that alienated stakeholders can impede newer attempts at integration.

Integration leaves a learning trail in its wake – a learning trail that has credibility because it took place in the same community for which additional integration initiatives are proposed.

On the other hand, if previous attempts at integration succeeded in convincing participants that integration was worthwhile, these participants may become supporters of, and mentors to, newer integration initiatives. Successful integration may also provide a pool of experienced participants willing to lend their expertise to additional integration initiatives.

Analysts may gauge integration based on the extent to which it met its goals.

People who experienced the integration may gauge it based on the degree of dislocation-pain it inflicted.

Both successful and unsuccessful instances of integration leave learning trails in their wake –learning trails that have credibility because they took place in the same community for which additional integration initiatives are proposed. Accordingly, an early step in any new integration initiative should be a “lessons learned” review of previous integration experience in the community.

Section 4

Does One Kind of Integration Work Better than any Other Kind?

While a great deal of research has been carried out on integration in health care settings, the research is of limited use in helping Ontario determine whether there are preferred approaches to integration across the province – for three reasons:

- Much of the research has been carried out in other jurisdictions. Learnings from these jurisdictions are not readily transferable to Ontario. Much research is US-focused, for instance, where health care relies more heavily on market forces than on forces of equity and effectiveness;
- Research results are often inconclusive, showing contradictory results; and,
- Only a small portion of the research compares one kind of integration with another to determine which is most successful under otherwise similar circumstances to achieve similar goals.

In Canada all other provinces have introduced integration models through regionalization of their

health care services, yet the implications of regionalization for integrated health care delivery have yet to be adequately assessed and reported.⁷⁵ And even if an improved base of research results were in place related to other provinces, these data would be of limited use to Ontario, where there is less policy emphasis on full or near-full integration as the route to achieve the goals of integration.

In short, there is no cookbook that can be used in Ontario to validate some forms of integration and to rule out others. However, the ingredients that could go into an integration recipe have been more thoroughly examined in the literature. Citations from the literature are included throughout this module, and the matrix of integration possibilities described earlier in the module synthesizes the results of research into an ingredient list.

While it is not possible to say whether some kinds of integration work better than others, it is possible to outline the major success factors for integration. These are presented in the module's next section.

What are the Success Factors for Integration?

Twenty success factors can be identified for integration. However, these twenty are not a closed list. Unique success factors can exist in any community, so the list outlined below should be seen as a starter kit.

While the list of success factors is an adaptation of work done by Mattessich, Murray-Close, and Monsey and described in their book *Collaboration: What Makes It Work*,⁶⁸ the list includes items drawn from the broader literature on integration.

5.1 Environmental Success Factors

These relate to the broader environment in which integration will take place, and include:

- ***A history of successful integration.*** This is often a success factor determined locally; and,
- ***A favorable political and social climate.*** This is often a success factor determined regionally or provincially.

5.2 Purpose-Related Success Factors

These relate to the reasons why integration is under consideration in the first place, and include:

- ***A shared vision driving the integration.*** A shared vision is not necessarily an identical vision. Each participant may have a personalized sense of the vision, yet these personalized visions must be complementary if not identical;
- ***Concrete, attainable goals and objectives.*** These are important to assure participants that what is desirable can actually be done and to provide a basis for pragmatic implementation; and,
- ***Vision, goals and objectives that are uniquely tailored to local circumstances.***

5.3 Participant Success Factors

Participation of willing capable people is crucial to the success of integration. Success factors related to this participation include:

- ***Mutual respect, understanding and trust among participants.*** These are part of organizational culture described earlier in this module;
- ***An appropriate cross section of participants interested in the integration.*** This is important to ensure that all those whose activities are necessary to make integration work are at the table, or willing and able to join the table. It is not enough, for instance, if only a few managers are committed to integration: many more people will be involved in making integration work on a daily basis;
- ***Self-interest as a motivator.*** Participants who do not see their own self interest (including the interest of those they are mandated to serve) reflected through integration will not likely help make integration a success;
- ***Ability and willingness to compromise.*** Integration often involves trade-offs and a willingness to change the way things are done for the sake of a greater good. Those who do not know how to compromise, or are unwilling to do so, make it difficult to negotiate trade-offs to arrive at “greater good” decisions; and,
- ***Role clarity for participants.*** While roles may evolve, they should be as clear as possible at any point in time. This helps avoid the unnecessary conflict, unmet role expectations, and anxiety about what is expected. Clarity should not be confused with rigidity, since role definitions can include scope for creative and entrepreneurial activity.

5.4 Leadership Success Factors

Leadership success factors include:

- **Leadership's legitimacy and credibility.** In many circumstances it is important to ensure visible legitimacy for leaders. A participating CEO or executive director who takes a leadership role, for instance, may choose to seek board approval to provide legitimacy in taking on the role. Credibility, however, has to do with whether a leader is seen to have the motivation and skills necessary to help lead an integration process; and,
- **Leadership skills.** These must be context-specific skills. A leader who has skills in hierarchical management, for instance, may need a different set of skills to help negotiate integrated activities among autonomous professionals or agencies.

5.5 Process and Structural Success Factors

These factors have to do with processes to achieve and maintain integration, as well as structures that act as pipelines through which the processes must flow. These success factors include:

- **Multiple layers of participation.** Not all participants and stakeholders may be willing and able to involve themselves in the same way in designing and operationalizing integration. Options should be available to allow participants to be involved in the right way at the right time with the right skills and motivation, with all participation nevertheless tied together by vision, goals, objectives and leadership;
- **Tailoring to fit local circumstances.** Processes and structures must make sense – and be seen as making sense – within the local context;

- **Flexible and adaptable processes and structures.** It is important that processes and structures be flexible so they can adapt to surprises, threats and opportunities; and,
- **An appropriate pace of development.** It is easy to underestimate the time it takes to create change. Enough time should be allotted to allow integration to be properly designed and commissioned, yet planning and commissioning should not stretch so far into the future that participant commitment drains away.

5.6 Communication Success Factors

These factors have to do with the informational glue that holds processes together. Module 5 in this Toolkit series, *Community Engagement and Communication*, provides additional insight into communication. Success factors for communication include:

- **Opportunities for open and frequent communication.** Communication must be both frequent and open so it can convey key messages, build cohesion, forestall rumors and misinterpretations, and maintain a focus on the purposes and methods of integration; and,
- **Informal relationships and communication links to augment formal relationships and communication.** Formal routes of communication are necessary, but informal ones are powerful because they use communication methods and channels chosen by the communicators themselves. Since integration brings people together, it is likely that integration will breed informal communication that will augment formal communication.

5.7 Resource Success Factors

These factors have to do with the energy necessary to make processes and structures work. They include:

- ***Sufficient funds to plan, implement and operate the integration.*** Most forms of integration require funding or other resource contributions to create and maintain the integration. It is essential to allocate sufficient funds and other resources (“in kind” resources in lieu of funds for instance), and to clearly identify the sources of these funds and resources. Whether they come from the organizations that are integrating their efforts or from an external funding source, it is important to be sure “investors” agree on the formula for contribution of funds or other resources (for instance, a formula based on the size of participating organizations). Investors should also be kept fully informed of the details of funding, to help prevent withdrawal by organizations that feel their investment is not matched by the investment of others; and,
- ***Sufficient human resources to plan, implement and operate the integration.*** These include paid staff (seconded or directly hired) as well as volunteers. Negotiating and keeping track of human resource contributions are important, again to forestall withdrawal by organizations that feel their human resource investment is not matched by others.

5.8 Using the Success Factors

During the exploratory and planning stages of integration, two questions about success factors are paramount:

- What is the current status of each success factor (how present or absent is each factor)?; and,
- What can/should be done to bolster each success factor?

Asking these questions at the beginning of an integration initiative can be a way to gauge readiness for change. These questions also need to be asked throughout the integration process, since they are not always fully answerable at the beginning of the process.

Appendix E provides a chart to aid integration participants as they pursue answers to these questions.

A Few Final Tips...

If you are involved in a leadership or partnership role in integration, the following tips may prove useful:

- 1. Acknowledge and deal with skepticism.** People may have had bad experiences with integration in the past – because it did not deliver on its promised outcomes, for instance, or because the pain of change outweighed the gains from change. But dealing with skepticism does not mean giving in to it. It means;
 - making it clear that integration will be carried out based on its merit in achieving important goals, not on whether it is initially popular; but also,
 - asking skeptics how future integration can be carried out without replicating past mistakes; and,
 - continuing to try to find common ground for support so that the values, norms and behaviours of stakeholders will support integration, or at least not undermine it.
- 2. Acknowledge and deal with optimism.** It is easy to be optimistic about integration when it is a theoretical principle. Achieving it so it works on a daily basis can be more difficult and can drain away initial optimism. Dealing with optimism involves managing its progress from in-principle optimism to pragmatic optimism, in part by maintaining a focus on achievable goals for integration and in part by ensuring that roadblocks are identified and resolved quickly and visibly.
- 3. Take the time to do it well.** Avoid falling into the “Zap! You’re integrated!” trap. It will take at least twice as long to integrate activities as you or others think it will, and the integration will be a series of progressive steps, not a sudden leap from un-integrated to integrated. Be sure your associates and your partners know this, and be sure a work plan for the integration is developed – a plan that includes interim milestones to recognize progress along the way.
- 4. Keep an eye on the goals.** These goals are, after all, your rudder – but integration can easily become an end in itself, divorced from any other ultimate goals, and therefore rudderless.
- 5. Do not shy away from hybrid approaches.** An integration initiative does not need to look pretty on an organization chart to work effectively in the real world – and a messy mix of approaches may work better anyway, because the real world is messy.
- 6. Build integration from the ground up,** identifying and understanding;
 - the specific clinical and support tasks that go into improving people’s health; and,
 - the specific dependencies (if any) among these tasks.
- 7. Advocate for support from the top.** If there are funding or regulatory policies that must be in place for integration to work, talk to the people who create policies, to enlist their support and help.
- 8. Build on successful integration that already exists** in the community or within a population. Failure to do this can result in the destruction of serviceable approaches that have pragmatic support from participants and real-world positive track records, only to be replaced by pretty new models that you – and perhaps only you – support.
- 9. Do not over-integrate.** If no goals can be met better by tight integration than by loose integration, opt for the loose integration.
- 10. Do not under-integrate.** The world is strewn with examples of well-intentioned stakeholders who promised to play well in the schoolyard without the need of a schoolyard referee. If structures and processes (the equivalent of referees) are needed to support those good intentions, make sure they are in place.

11. **Remember that successful integration is a form of community engagement, requiring extensive stakeholder communication.** Module 5 (*Community Engagement and Communication*) in the Health Planner's Toolkit provides extensive material on community engagement and communication that will be helpful during integration processes.
12. **Remain sensitive to integration's human resource dimensions.** Integration affecting the job status or employment conditions of employees has both ethical and legal implications. Ontario's *Local Health System Integration Act, 2006*, has created labour relations mechanisms for an orderly integration of staff/employees in the larger integration context (i.e., application of the *Public Sector Labour Relations Transition Act* and consequential amendments to it, and requirements for the parties to an integration to develop human resources adjustment plans).
13. **If you make a mistake, back up and fix it.** But to do this, you need to know you made a mistake in the first place. Constant monitoring of any integration process will help give you that information. Monitoring should include input from a wide range of stakeholders, not just those who are intimately involved in carrying out the process.
14. **Keep in mind the importance of behavioural incentives.** People and organizations will not cooperate as implementers of integration unless they are consistently, fairly, quickly and appropriately rewarded for doing so. Keep in mind too that not all incentives are selfish. A stakeholder may help make integration work because it makes her life easier, but she may also cooperate because she is kept informed of the health gains to her clients that stem from integration.
15. **Remember – you cannot do this all by yourself.** It has been suggested that the dynamics of integrated organizations are like a marriage, with communication and relationship building as important determinants of success.⁷⁶ Appendix E reproduces guidelines based on experience in community collaboration for creating inter-organizational relationships.

Summary

This module provides a three dimensional matrix that should help participants in integration to make decisions about the degree, types and components of integration. The module also offers a thinking path for integration initiatives as an aid in making integration decisions.

While there is no “cookbook” that can tell a reader what recipes for integration work better than others, this module identifies twenty success factors that can be taken into account when planning and initiating an integration project.

It is also important to note that integrated structures without integrative processes will be hollow shells, while integrative processes without integrated structures will lack a foundation of support. Both the processes and the structures of integration warrant consideration.

Integrated structures without integrative processes will be hollow shells, while integrative processes without integrated structures will lack a foundation of support.

Although this module suggests that integration does not require and does not necessarily lead to a system monolith, the issue for organizational patterns of integration is the extent to which they really are system-like in their operation. Appendix C presents examples of questions that go beyond the mere listing of integration forms and strategies to gauge the “systemness” of integrated entities.

At several points this module addresses the importance of organizational culture, both as a component of integration and as a facilitator for other dimensions of integration. In keeping with the emphasis on organizational culture, it is important to bear in mind that integration is not only about people behaving rationally in the face of evidence about the benefits or drawbacks of any form of integration. Integration is also about deeply held beliefs and norms, and about passionate commitment to preserving and building on the best of what is already in place, while recognizing an equally passionate commitment to making things better for clients, families, health service providers, funders and regulators.

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Appendix A

Continuum of Care

From Conrad D. Coordinating patient care services in regional health systems: the challenge of clinical integration. Hospital & Health Services Administration 38(4) Winter, 1993²⁰

Vertical Integration and the Continuum of Care		
Nature of Vertical Integration	Degree of Vertical Integration	Stage in the Continuum of Care
Coordinating episodic, short-term services only	Least ↓	Acute hospital inpatient care
Linking episodic inpatient services to subsequent advanced specialty care	Somewhat more downstream integration ↓	Tertiary subspecialty care
Joining range of specialty services within the system and specialists coordinating care for selected patients	Increasing integration ↓	Secondary specialty care
Beginning system linkages between episodic and chronic care services Greater downstream integration	Greater downstream integration ↓	Long-term care
Advancing system coordination from acute and custodial care toward long-term improved functioning	Further forward (downstream) integration ↓	Rehabilitation services
Moving to coordinated tertiary, secondary, and primary care services Virtually complete integration of care for “illness”	Virtually complete integration of care for “illness” ↓	Primary care
Coordinating the person’s health life cycle	Total integration of illness and “wellness” services	Health promotion and disease prevention

Clinical Team Integration Models

From: Boon H, Verhoef M, O'Hara D, Findlay B. From parallel practice to integrative health care: a conceptual framework. BMC Health Services Research 2004, 4:15 <http://www.biomedcentral.com/1472-6963/4/1577>

Parallel

- characterized by independent health care practitioners working in a common setting
- each individual performs his/her job within his/her formally-defined scope of practice

Consultative

- expert advice is given from one professional to another; this may be via direct personal communication, but is often via a formal letter or referral note

Collaborative

- practitioners, who normally practice independently from each other, share information concerning a particular patient who has been (is being) treated by each of them
- these collaborations are ad-hoc in nature and usually occur informally on a case-by-case basis

Coordinated

- a formalized administrative structure requires communication and the sharing of patient records among professionals who are members of a team intentionally gathered to provide treatment for a particular disease or to deliver a specific therapy
- a case coordinator (or case manager) is responsible for ensuring that information is transferred to and from relevant practitioners and the patient

Multidisciplinary

- is characterized by teams, managed by a leader (usually not a physician) that plans patient care
- one or two individuals usually direct the services of a range of ancillary members who may or may not meet face-to-face
- each individual team member continues to make their own decisions and recommendations which may be integrated by the team leader
- is a highly articulated and formalized outgrowth of coordinated practice

Interdisciplinary

- emerges from multidisciplinary practice when the practitioners that make up the team begin to make group (usually based on a consensus model) decisions about patient care facilitated by regular, face-to-face meetings

Integrative

- consists of an interdisciplinary, non-hierarchical blending of both conventional medicine and complementary and alternative health care that provides a seamless continuum of decision-making and patient-centred care and support
- is based on a specific set of core values that include the goals of treating the whole person, assisting the innate healing properties of each person, and promoting health and wellness as well as the prevention of disease
- employs an interdisciplinary team approach guided by consensus building, mutual respect, and a shared vision of health care that permits each practitioner and the patient to contribute their particular knowledge and skills within the context of a shared, synergistically charged plan of care

System Integration Scales

Adapted from Appendix A, List of HSIS System Integration Scales, found in Gillies RR et al. Conceptualizing and measuring integration: Findings from the Health Systems Integration Study. Hospital & Health Services Administration. 1993; 38(4): 467-489⁵

This list of questions was used in a study of health care systems participating in the early 1990s Health Systems Integration Study (HSIS) in the United States. Respondents were asked for the extent to which they agreed or disagreed with the statements describing various components of clinical, functional, and normative integration, resulting in measures of perceived integration in these areas. (The original study used functional, physician-system, and clinical integration as its major categories.) They illustrate the range of possible items to which the broad components in the matrix of integration possibilities only alluded.

1. Functional Integration

1.1 Human Resources Integration

- Performance appraisal criteria and reward systems contain incentives for cooperation and coordination across operating units.
- Wage and salary guidelines are provided for all operating units.
- Operating units are assisted in their personnel recruitment activities.
- Personnel are cross-trained and used across operating units.
- Employee training programs are shared across operating units.
- When job openings exist, postings and communications are made available to all eligible personnel across the operating units.
- Standard personnel policies exist for all operating units.

1.2 Support Services Integration

- There is little unnecessary duplication of support services (dietary, housekeeping, maintenance, laundry, etc.) among operating units.

- Support services (dietary, housekeeping, maintenance, laundry, etc.) are combined across operating units to provide efficient service.
- The work of support staff and services (dietary, housekeeping, maintenance, laundry, etc.) is well-coordinated across operating units.

1.3 Strategic Planning Integration

- Each unit understands the strategic role that it is to play within the system's overall strategy.
- Individual operating units are willing to subordinate their individual interests to those of the system.
- Appropriate guidance is provided to help operating units develop their strategic plans.
- Operating units always know what is expected of them with regard to the system's goals and objectives.
- Each operating unit's strategic plans are well integrated into the system's overall strategic plan.
- Each operating unit has sufficient input into the system's overall strategic plan.
- System-wide goals and objectives are agreed on and widely shared by all operating units.
- Elements of the overall system strategic planning process are well coordinated.

1.4 Quality Assurance Integration

- Results from quality assurance/improvement studies are shared across operating units.
- Good communication exists across the operating units with regard to quality assurance/improvement policies and practices.
- Risk management, utilization review, and quality assurance/improvement activities are well integrated across the operating units.
- Common policies for quality assurance/improvement exist across the operating units.
- Operating units are provided assistance in the development of quality assurance/improvement policies and practices.

1.5 Marketing Integration

- Operating units are assisted in conducting market research.
- Marketing plans are well coordinated across operating units.
- Advertising and promotional activities are well coordinated across operating units.

1.6 Information Systems Integration

- Integrated clinical and financial data are shared across operating units.
- Useful clinical data is provided to the operating units.
- A single medical record exists for all patients regardless of point of entry into the system.
- Operating units share a common management information system.

1.7 Financial Management Integration: Resource Allocation

- Revenues and surplus funds are allocated across operating units to enable them to respond to larger opportunities.
- Cash management is handled centrally for the operating units.
- Decisions to invest in new services are evaluated in relation to system-wide priorities.
- Each operating unit uses system-established financial criteria in making major hospital purchases rather than its own criteria.
- Resources are allocated based primarily on system-wide priorities rather than individual operating units' needs.

1.8 Financial Management Integration: Operation Policies

- Accounts receivable policies are standardized across operating units.
- Operating budgets are well developed and coordinated among all operating units.

- Useful comparative financial data is provided to the operating units.
- Individual operating units understand the system's overall financial investment policies.
- Operating units participate in a common purchasing program.

2. Clinical Integration

- Clinical activities and services are well coordinated between and among operating units.
- There is little unnecessary duplication of clinical facilities and services among operating units.
- Where possible, clinical services are appropriately shared among the operating units.
- Clinical services and facilities are appropriately integrated to achieve cost-effective patient care.

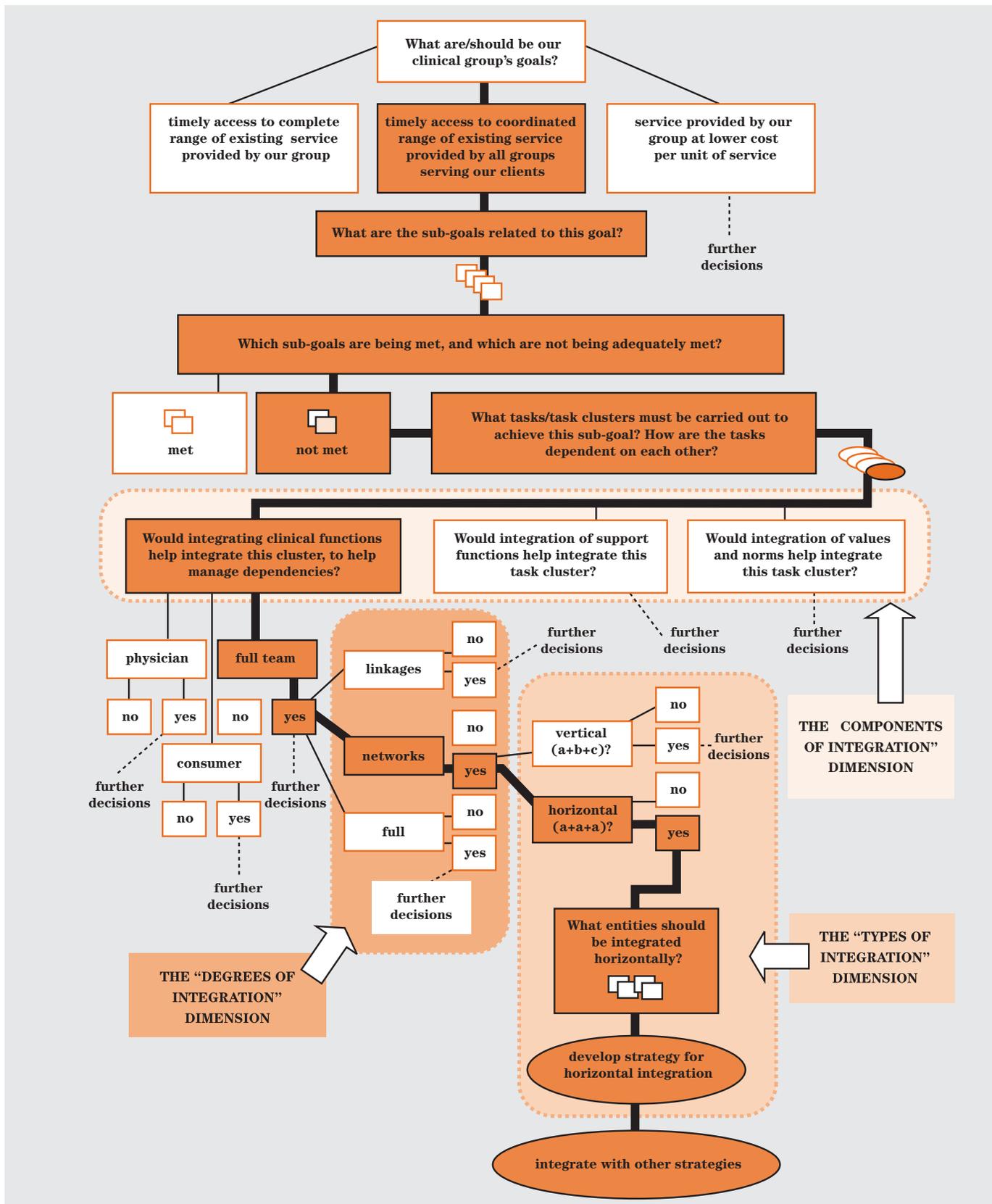
2.1 Physician-System Integration

- The medical staff of the operating units share common goals, philosophies, and methods of operation.
- Clinical activities and services are well coordinated between and among operating units.
- A plan exists for coordinating medical staff development across the operating units.
- Common policies and practices regarding hospital-based physicians exist across the operating units.
- Common guidelines for reviewing physician privileges and credentials exist across the operating units.
- The medical staff at each operating unit believe in sharing resources with other operating units.
- The medical staff at each operating unit have a high degree of commitment to the system overall.
- The medical staff at each operating unit practice in a way that takes into account the activities and needs of other units.

3. Cultural (Normative) Integration

- System-wide values and norms are agreed on and widely shared by all operating units.
 - Operating units always know what is expected of them with regard to the system's goals and objectives.
- System-wide goals and objectives are agreed on and widely shared by all operating units.
 - Operating units have a good understanding of “how things are done” within the system.
 - Employees within and across the operating units feel connected by a common set of system-wide values and norms.

A Thinking Path for Integration Initiatives



Success Factors for Integration

A. ENVIRONMENTAL SUCCESS FACTORS		
What is the success factor?	What is the current status of this success factor?	What can/should we do to bolster this success factor?
1. There is a history of successful integration.		
2. There is a favourable political and social climate.		
B. PURPOSE-RELATED SUCCESS FACTORS		
What is the success factor?	What is the current status of this success factor?	What can/should we do to bolster this success factor?
3. A shared vision drives the integration.		
4. The integration has concrete, attainable goals and objectives.		
5. The vision, goals and objectives are tailored to local circumstances.		
C. PARTICIPANT SUCCESS FACTORS		
What is the success factor?	What is the current status of this success factor?	What can/should we do to bolster this success factor?
6. Mutual respect, understanding and trust exists among participants.		
7. An appropriate cross section of participants are interested in the integration.		
8. Participants see integration as in their self-interest.		
9. Participants have the ability and willingness to compromise.		
10. The roles of participants are clear.		
D. LEADERSHIP SUCCESS FACTORS		
What is the success factor?	What is the current status of this success factor?	What can/should we do to bolster this success factor?
11. The leadership group is seen as legitimate and credible within unique local circumstances.		
12. The leadership is skilled.		

E. PROCESS AND STRUCTURAL SUCCESS FACTORS

What is the success factor?	What is the current status of this success factor?	What can/should we do to bolster this success factor?
13. Processes and structures allow for multiple layers of participation.		
14. Processes and structures are tailored to local circumstances.		
15. Processes and structures are flexible and adaptable.		
16. The pace of development is appropriate.		

F. COMMUNICATION SUCCESS FACTORS

What is the success factor?	What is the current status of this success factor?	What can/should we do to bolster this success factor?
17. Opportunities for open and frequent communication exist or can be created.		
18. Informal relationships and communication links augment formal relationships and communication.		

G. RESOURCE SUCCESS FACTORS

What is the success factor?	What is the current status of this success factor?	What can/should we do to bolster this success factor?
19. Sufficient funds exist to plan, implement and operate the integration.		
20. Sufficient human resources exist to plan, implement and operate the integration.		

Building Organizational Relationships

Reproduced from the Community Tool Box, Community Building Tools, Part G, Implementing Promising Community Interventions; Chapter 24,. Improving Services; Section 3, Promoting Coordination, Cooperative Agreements, and Collaborative Agreements Among Agencies. Accessed January 29, 2006 at http://ctb.ku.edu/tools/en/sub_section_main_1229.htm⁷⁸

Where do you begin in building organizational relationships? Here are some general ideas of how to get started. These are basic guidelines that may be helpful and sometimes necessary to begin any such relationship.

1. Involve the stakeholders.

Make sure that everyone who is affected is involved in the process, directly or indirectly. Who is that? It includes all the stakeholders (that is, everyone who has a stake in the outcome), including leaders of the organizations, staff who will implement the programs, constituent groups of the organizations, people who will be involved in the programs, the larger community, and people who may be affected indirectly.

Why should you involve all these groups? Because if you want your effort to succeed, you will need the cooperation and, better yet, the help of those who can benefit from a good outcome. The level of involvement among the different groups will vary. Some people will come to every meeting, while some people may only fill out one survey, and everything in between. The important thing is to make sure that people know they have a real say in a project that will affect their lives.

For example, if you are going to have a few organizations work together to expand the counseling hours of a teen counseling center, you will want to get input from counselors, teens themselves, parents and teachers, neighbors who live around the center, and any one else who could potentially help or hinder your program. By doing so, the teen center will run more effectively.

2. Establish one-to-one relationships, and begin to build trust.

It may seem obvious, but an organizational relationship is built on many one-to-one relationships between members of each organization. People who will be working together and taking risks together will need to get to know each other and establish trusting relationships.

This can begin in a variety of ways. For example, a person or two from each organization might get together for lunch. Or a few people from each organization can meet for informal discussions, retreats, social events, or other informal gatherings. Often a skilled facilitator can help by conducting exercises or leading discussions.

Whatever method you use, make sure to:

- Take it slow. Trusting relationships take a while to develop. Don't give into feelings of urgency or having to "get things done quick." Establishing trusting relationships is the most important preliminary step; it will provide a foundation for all other actions.
- Make sure that, at some point early in the process, each person involved gets time to talk about themselves, their organization, their stake in the issue and community, their interest in the partnership, and their concerns about the relationship.
- Establish guidelines that people will be honest with each other, respect confidentiality (when decided upon), and be responsible to the group.
- Establish a tone of cooperation. Help people understand that they might be able to advance each other's goals.
- Build communication skills. As people get to know each other, help them learn to communicate in ways that are most productive. Again, a facilitator can help here.

Once people have gotten to know each other, trust should continue to build. And as people work together successfully, trust will grow naturally. Throughout the relationship, you should be aware of the trust level of the group. If something happens that endangers trust, make sure action is taken to repair the trust and keep it growing. Other suggestions in this list also will contribute to building trust in an organizational relationship.

3. Clarify the goals each organization wants to accomplish.

Each organization should clarify its need for a relationship, its definition of the problem, and how it thinks an organizational relationship could help. The time necessary for this process will vary, depending on how many organizations are involved and the scope of the problem. If a few organizations are meeting to network, this process won't take much time. If, on the other hand, this is a multisector collaboration in which people haven't yet defined the problem, this process will take a while, and that should be built into the plan.

4. Decide on an organizational relationship that makes sense.

Once needs, goals, and resources have been clarified, choose the kind of relationship that makes sense. For example, is it better for us just to network at this time, or are we ready to cooperate or collaborate more actively?

5. Establish procedural ground rules.

Early on in the relationship, establish ground rules for important procedures, such as:

- How decisions will be made
- Who will speak to the media
- What should be considered confidential
- How information will be distributed
- The role of representatives, and
- Any other important procedural guidelines.

Ironing out these policies early will prevent mistakes and misunderstandings. It is especially important to avoid any decision-making that goes on in unscheduled sessions at which all partners are not included.

6. Learn how to listen.

It can't be said enough: learn how to listen. Group process is at the core of making organizational relationships work well. So many decisions must be made in a group and so much information needs to be exchanged. And in order for people to begin to see each other as partners, they need to tell each other what is important to them – their values, their experiences, and their ideas – *and* they need to know they are *heard*.

Each person involved needs to be able to put aside his or her own concerns long enough to listen to others. All this sounds so simple, but it can be difficult, especially when the risks are high and everyone has emotions related to the outcomes. Still, it is important that the group develops listening skills – and you can lead group exercises that will help people learn how to listen well.

For example, give everyone a turn to speak for a few minutes without being interrupted, or break into pairs and have each person take a turn to talk for five minutes while the other person listens. These simple exercises can let everyone have a chance to think without being interrupted. It can clear people's minds so they are more able to listen to someone else.

7. Build on points of agreement.

Don't require people to agree on every point. There will be diversity of opinion, and that is good. Keep track of what people agree on and build on those ideas. If people can't agree on an entire program, work towards winning people over to a building-block agreement, in which they agree to smaller pieces of a program. Once part of the program succeeds, people might be more inclined to add more blocks to the structure.

8. Learn about each other's cultural group.

As mentioned above, it is important when organizations cross cultural lines that members learn about the culture and possible oppression of their organizational partners. Taking the time to do this will build trust and prevent problems and crises from taking place.

Cultural celebrations can help build understanding. Also, facilitators can lead discussions and exercises that will help people talk about their cultures and their experiences of oppression. These kinds of exchanges can help people from all perspectives heal from the hurts of oppression and discrimination. Also, most people sincerely want to learn about cultures other than their own.

When people go through this kind of exchange and healing process they usually have a stronger sense of unity. They also often feel more ownership in the organizational relationship and may be more ready to participate in it fully.

9. Don't require organizations to give up their identities.

Each organization has its own unique identity and culture which holds its members together. Joining efforts with another organization may worry some members that their own organization's identity will be diminished. Leaders should reassure members that the identity of their organization will stay intact and that joining efforts with another organization does not mean the two organizations will blend into one.

10. Expect problems and disagreements – and exhibit patience.

You will have setbacks, and upsets, and disagreements. That is part of the process and you should not become discouraged when this happens. Make time to listen to people voice their concerns and try to resolve the problem. Then, minimize the divisions, focus on what has been accomplished, and set out again to reach your next goal.

11. Celebrate every success, large and small.

We all need some fun and connection with others to help us keep our eyes on the prize. Celebrating helps people maintain their excitement, recognize the progress being made, and focus on the next step. Whether it's a pizza at the end of a meeting or a gala ball, don't forget to celebrate. "All work and no play make a dull organization."

Four additional rules for successful multi-sectoral collaboration include:⁷⁹

1. The scope of the collaborative project should be clearly defined.

What exactly do you want to accomplish together? For example, you may start with wanting to improve outreach efforts to youth in a particular neighborhood. What activities will be undertaken? And how will you know if outreach efforts have improved? As specifically as possible, describe the activities and the standards by which you will measure both activities and outcomes.

2. Each partner should know how the collaboration will advance the interests of its organization and clients.

Beyond the common goals, what does each party want? Community organizers know that to make a coalition work, self-interest plays a critical role. One director may be worried about her organization's financial health, another director may want access to new services, and another may see working together as a way to gain power in the political process. Whatever the personal goals are of individual leaders or specific interests of individual organizations, it helps to be honest about them so that no important agendas remain "hidden." In addition to discussing what each party wants, it may also be important to address each party's fears and concerns.

3. Roles and responsibilities should be defined, and mechanisms for communication and joint accountability should be in place.

What can each party give? Even among "small" agencies, each with the same or similar missions and clientele, there will be differences in financial stability, management capacity, facilities, board leadership, and access to political power. What resource(s) is each party able to give and what is each willing to give to support the joint effort? Collectively these resources must match the requirements of the project scope discussed in Rule 1. If they don't, either the scope is too broad, or you have the wrong mix of organizations at the table. Beyond "who will do what by when?" how will you hold yourselves accountable – through regular meetings, financial incentives/penalties related to performance, or through other means?

4. The relationship should work: there should be enough trust and respect among the key players to support the level of risk and interdependence involved in the project.

The most difficult aspect of collaborations, and the least concrete, is the relationship between the partners. A low intensity project such as sharing information on service schedules does not involve “high stakes” and therefore requires less trust and the respect between

partners. However, in a joint service contract the level of trust and the respect between partners is the intangible element that will either make or break the project: no contract can spell out every possible eventuality. Are we able to communicate effectively? Are the right people involved? Can the relationship among the participants support the kind of honest talk and genuine listening required to work together successfully?

Notes

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