

Care Transitions, Integration and Leadership

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ABSTRACT

This paper examines three important and interrelated concepts pertinent to the provision of high quality health care namely care transitions, integration and leadership. The population focus is seniors over the age of sixty-five living within the geographical boundary who access care and services across the continuum. The examination illuminates some of the current challenges, opportunities, barriers and gaps identified in the literature and to draw out pertinent evidence to support future practices. Nurse leaders are well positioned to make a significant contribution to patient-centered care and integration by drawing together the strands of the management of care systems, cross-boundary working and thinking and the effective allocation of resources.

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Preamble

The motivation behind my examination of these concepts resides in the beliefs I hold about the importance of patient-centered quality care, interdisciplinary collaboration and communication and the role that leadership plays in contributing to how this unfolds in practice in the everyday organizational reality. A career in health care, spanning more than twenty-five years, has afforded me first-hand experience with the three salient concepts selected as the focus of this paper, namely care transitions, integration and leadership. Their centrality to care quality, safety and patient outcomes in the ‘seamless continuum of care’ is undeniable. The research and evidence analyzed for this examination contradicts the seamless notion of the health care system and service delivery. The opportunities for fragmentation of care, services, and communication are numerous. The potential for patients to ‘fall through the cracks’ has been studied and reported on by experts from around the globe, leaders from large healthcare and quality and safety organizations, academics and most importantly, the recipients of care. My experience in a variety of roles and programs, from front-line nurse to senior practice leader, corroborates the concerns related to poorly managed care transitions and endorses the need for change.

An ongoing interest in leadership theories and practice prompted my pursuit of this complex and ambiguous topic. As an emerging leader, I attended several training and competency development sessions hosted by a variety of organizations. The content of these workshops was predominantly aligned with the traditional trait theory and style model approaches (i.e. task-centered versus people-centered). It was interesting and somewhat perplexing to me that the broader context of leadership, situated in and enacted in organizational life, was dismissed. Subsequently, my experiences as a program/project manager and senior practice leader contributed to the development of a more skeptical view that practising leadership

resided entirely within the individual's enactment of the role. To deny the importance and existence of followers and culture in shaping leadership was disconcerting. Through this examination and inquiry, I have developed a broader view of the concept and a greater acceptance regarding the complexity, ambiguity and inconsistency inherent to the study and practise of leadership. Zaccaro and Horn (2003) argue that leadership theory has not lived up to its promise of assisting practitioners in resolving the challenges and problems that occur in everyday organizational leadership. Many of the current theories and models not contextualized and the dynamic and critical challenges confronting leaders are not the drivers of their theoretical construction. Without more effective integration of theory, research and practice, their value remains limited. Several unanswered questions continue to unfold for me: What is it about leadership that is fulfilling? Why are we compelled or motivated to pursue the role? How can we practise leadership that is congruent with the existing social context while maintaining a patient-focused approach? The contemporary theories that account for these ambiguities, tensions and inconsistencies better represent today's reality and endeavour to connect theory and practice. I acknowledge and respect the paradox that prevails with our comfort and confidence in leadership in the absence of a clear meaning—and am further convinced that leadership is not the 'panacea' to all that 'ails' health care.

Introduction

This paper examines three important and interrelated concepts pertinent to the provision of high quality health care namely care transitions, integration and leadership. The Northern Health Authority provides the geographical and regional context for this examination. Under the leadership of Anne Chisholm, Interim Health Service Administrator for Prince George, this paper will build on the work I consulted on and contributed to previously conducted in 2012 entitled *Integrated Care for Seniors in Prince George*. The population focus is seniors over the age of sixty-five living within the geographical boundary who access care and services across the continuum. The examination illuminates some of the current challenges, opportunities, barriers and gaps identified in the literature and to draw out pertinent evidence to support future practices. Information from a variety of sources is included: academic literature, key regional, provincial and federal documents/reports, relevant regulatory and legislative policies, regional health authority data extrapolated from existing data bases, and key stakeholder discussions. Based on the synthesis of the evidence, some of the prevailing discourse surrounding these concepts will be challenged. This concept paper takes as its point of departure the position that a rethink regarding leadership's role and the value proposition in supporting effective care transitions for patients and their families is warranted. To better understand and illustrate the current state of care for seniors as they move across the continuum, two previously completed patient care journeys are appended as exemplars. Strategies for improving the quality of transitions in patient care, improved coordination and integration of services and future work are included.

Background and Context

Northern Health delivers health care across Northern British Columbia, serving approximately 300,000 people and covering a vast rural region covering the northern two-thirds of the province. Approximately 17.5% of the population is Aboriginal. Many of the communities served have fewer than 5,000 persons. Small communities and their rural context present some unique service delivery challenges, such as:

- Economies of scale are difficult to realize. Resources are expended to mitigate the impact of distance and travel.
- The referral process, care coordination and knowledge exchange between case managers, health professionals, other providers and clients become fractured.
- Supporting infrastructures such as high speed internet and public transportation are not sustainable and/or do not exist.
- Significant rural human resourcing issues add another level of challenge not typically found in urban settings. (Northern Health, PowerPoint Presentation, February 2013).

Health services currently delivered by Northern Health include, but are not limited to: acute (hospital) care, mental health and addictions, preventative health, community and residential care. Northern Health is divided into three Health Service Delivery Areas (HSDAs):

- Northeast
- Northern Interior
- Northwest

The Chief Executive Officer (CEO) is Cathy Ulrich. A Chief Operating Officer in each of these HSDAs holds executive management authority and responsibility and reports directly to the CEO. Anne Chisholm, Interim Health Service Administrator for Prince George and senior operational leader for this paper, reports to the Chief Operating Officer, Northern Interior Health Services. The health region is governed by a ten-member board with representation from across the North.

In 2010, Northern Health began its journey to better understand the systems related to primary care and how they were delivered within the region. Northern Health's vision is to provide integrated health services for all individuals within the health authority, built on the foundation of primary care (Northern Health Strategic Plan, 2009-2015). The aims identified in the strategic plan include:

- Integrated accessible health services
- A focus on our people
- A population health approach
- High-quality services

The vision proposes an aspirational goal that people will experience seamless and coordinated service. The "Primary Care Home" is defined as the foundation for multidisciplinary health care and helps people navigate across services. Congruent with the vision and strategic focus was the Integrated Health Care for Seniors in Prince George Initiative, sponsored by the Chief Executive Officer and lead by Anne Chisholm, Director, Community & Residential Services in Prince George at the time. This important work was initiated in December of 2011. The report, submitted in April 2012, highlighted policy directions, issues, gaps and barriers along the

continuum of care for seniors residing in Prince George. The aim in designing integrated health care for seniors in Prince George is to move from disconnectedly reacting, solving problems and managing ‘pieces’ to developing people and systems to lead transitions in care that fulfill the whole system through communication (Northern Health, PowerPoint Presentation October 2012).

As health care providers strive to meet the growing service demands with strained resources, staff and leadership are concerned about their ability and capacity to meet the needs of seniors currently and given current projections, while ensuring timely access to care across the continuum (e.g. primary care, hospital based care and/or community care). Seniors care, as a sector, encompasses a variety of services and supports ranging from long-term residential care to home and community-based care and the concerns for this population in relation to meeting organizational goals are particularly high. The reasons for this will be outlined in the following section.

With a focus on improving transitions in patient care, it is necessary to look beyond the delivery of acute care services and to design a more effective and coordinated continuing care system. The current legislative context for community services is articulated in the purpose section of the Continuing Care Act, 2010:

- To ensure that a wide range of community services is available to people in their own homes and in other community settings so that alternatives to institutional care exist
- To provide support and relief to relatives, friends, neighbours and others who provide care for a person at home

- To integrate community services that are health services with community services that are social services in order to facilitate the provision of a continuum of care and support.

Continuing care programs include home support services, adult day center services, meal programs, continuing care and case management services, home care nursing and home oxygen delivery. In and of themselves, these are all discrete services that can be organized and delivered into people's homes in the community but may not be 'integrated' in ways anticipated by the strategic plan of the health authority. The range of continuing care services are often referred to in health care as 'downstream' services and supports which may unintentionally minimize their value in their contribution to population health outcomes. An effective system of home and community care can help seniors live healthy, independent lives, reduce pressure on hospital and facility beds and costly emergency services.

The case for change is evident in the shared realization that the current supply and the growing demand for integrated services within the broad and diverse seniors population will make it difficult to sustain a viable system of access to quality care and services across the continuum without a focused redesign effort. A number of significant factors that drive the need for change are identified:

- Northern Health will be significantly challenged by the projected growth of the senior's population. Although the percentage of seniors in the region's overall population is currently the lowest of all the health regions (approximately 10%), it is expected to grow rapidly over the next fifteen years from 2010 to 2025. During this period, the 65+ and

75+ populations are expected to grow by 93% and 97% respectively (BC Stats: PEOPLE 35).

- The Northern Cancer Prevalence Projections: Custom Analysis for Northern Health by the BC Cancer Agency reported in 2010, Northern Health expects to see 1,207 new cancer diagnoses. By 2020, this number will increase to 1,620 annually. In response to this growing demand and to meet the needs of northern communities, the Northern Cancer Control Strategy (NCCS) has been developed in partnership with the BC Cancer Agency and the Provincial Health Services Authority. The strategy includes a range of services to bring cancer care closer to home.
- The region is experiencing waitlists for residential care, including clients who are designated ‘difficult to serve’ (e.g. those with behavioural issues, acquired brain injury, etc.). The percentage of people waiting for placement for 90 days or greater as of December 15, 2011 is 70.9% and indicates a growing trend (January 2012 NH Scorecard Summary).
- There is a need for improved integration and coordination of services, and a shift in philosophy from the emphasis on the bio-medical or curative model of care to a supportive model that focuses on care, support and ‘enablement’ (Hollander and Prince, 2002).
- The health authority has identified priorities in the areas of Primary Health Care and Home Care and a commitment to invest in these areas. Northern Health will continue to enact and direct resources toward its strategic plan and priorities.

- The provincial government recently announced a partnership with the BC Medical Association focused on improving primary care services to ensure all citizens in B.C. who want a family physician will have one by 2015 (February 22, 2013).
- The provincial government has also declared its interest and support in expanding primary and community care. Just prior to the recent provincial election (May 2013), the then Minister of Health, Margaret MacDiarmid, announced regional health authorities will receive up to \$50 million annually over the next three years for targeted primary and community care programs to better support patients and their families. These community-based programs will be customized to local needs and will focus on enhancing supports for patients with complex chronic conditions, mental health and substance-use challenges and seniors with complex care needs. The aim is to keep people out of costly acute and residential care and align with a more supportive ‘home is best’ philosophy. Northern Health has been allocated \$2.1 million in targeted funding to enable seniors with complex care needs, those with mental health and substance-use challenges and people with chronic disease in three communities: Prince George, Fort St. John and Fraser Lake (March 1, 2013).
- The proportion of funding for clients with long-term health needs has increased only slightly year over year, while at the same time the needs of seniors are becoming more complex and the population is growing. Changes are needed in how home and community care services are organized and integrated within the broader health care system. The need to integrate home, community and primary care services for seniors with chronic and complex health needs is recommended (Caring for BC’s Aging Population: Improving Health Care for All, 2012).

- Although there are a range of services available for individuals with long-term health needs, a range of issues, gaps and barriers exist. Accessing the right service at the right time for the identified level of need remains an issue. These issues comprise supply-demand pressures, sustainability for community agencies, adequate supports for family caregivers and ongoing challenges for case managers.
- Older adults moving between different healthcare settings, sites and services are vulnerable to receiving fragmented care. Health care delivery is divided into ‘pieces’ that often function in isolation and in silos. Patients often assume transitions are carefully planned and information is shared.
- Poorly executed care transitions contribute to a variety of adverse outcomes, some of which include: conflicting care recommendations regarding chronic disease or self-management, confusing medication regimes with a high potential for error and/or duplication, lack of follow up care and inadequate patient and caregiver preparation for care in the next setting, patient/caregiver distress, greater use of hospitals and emergency services, and increasing health care costs.
- The more medically complex the patient, the more likely they will experience multiple transitions. Those with poor transitional care are more likely to ‘fall through the cracks’ (Coleman, 2003; Coleman and Fox, 2004; Graham et al, 2009).
- Patient safety research reports that the cumulative effect of errors that occur during care transitions can result in significant harm or possibly, death (Institute of Medicine, 2001; Berwick, 2002; Leape et al, 2009, Institute for Healthcare Improvement 2006).
- The patients and their caregivers are often the only common elements moving across sites of care and need to be involved as active participants in decisions about their care. They

can make valuable contributions to their healthcare safety and efficacy as their needs change over time.

The information and data provided above represents a synthesis of the literature and the documents reviewed, relevant website exploration, focused discussions with the Interim Health Service Administrator, my thesis supervisor and experiential knowledge acquired in health care.

Care Transitions and Integration

The concepts of care transitions and integration are popular and frequently researched topics in the literature. The research encompasses a broad range of literature and includes: quality improvement, patient safety, nursing, gerontology, family medicine, primary care, organization and business, public health and social and health care policy in addition to numerous provincial and national reports. However, the frequency with which it has been studied has not contributed to clarity of meaning. Care transitions have been described as a major contributor of confusion and miscommunications for patients, families and healthcare providers. Adding to this confusion and complexity is the interchangeable way in which language is used to describe the phenomena, such as: transitional care and care transitions, continuity of care, care coordination, seamless care, integrated care and integration. The lack of consensus around the conceptual definitions is also problematic. The following discussion defines these terms for the purposes of this paper based on the research/evidence reviewed.

Continuity of Care—is a series of connected patient care events both within a health care institution and among multiple settings and requires linkages across time, settings, providers and consumers (Sparbel and Anderson, 2000). Described by the authors as a tenet of clinical nursing practice, efforts to ensure continuity have been poorly defined, scattered and largely dependent

upon individual and community resources. Their exploration of research reported between 1990 to 1995 revealed that many of the studies conducted and published on continuity of care do not specify continuity of care as the central construct. In essence, it became a by-product of the research—a surprising finding given its integral relationship in practice. If we support the premise that continuity of care is a critical feature in delivering quality health care services and contributes to better outcomes, it is problematic that few interventions have been developed to assist older patients and their families in making smooth transitions.

Waibel et al. (2012) reported a qualitative meta-synthesis on a literature search using the subject heading “continuity of care.” Content analysis was completed and themes identified related to the aggregation of findings, based on three types of continuity across care levels:

- Relational—consistency of personnel and ongoing patient-provider relationship
- Informational—information transfer and accumulated knowledge
- Management—consistency of care, flexibility and accessibility

The results highlighted the importance of continuity for patients with chronic health problems, the elderly, young parents and palliative clients receiving home care. Information transfer and communication among care levels and providers was highly valued by patients overall as they were spared from the unnecessary repeating of information or tests, delays in progress and recovery, and increased anxiety. Consistency of care based on a care plan adaptable to changing care needs was important. The synthesis identified the emphasis was placed on discharge planning and the process as opposed to individualized care planning and pathways. This is congruent with the traditional ‘curative’ view of reacting to and endeavouring to fix the problem.

Reid et al (2002) initially developed and introduced the conceptual framework that comprised the typology described above. They defined continuity of care as one patient experiencing care over time that is both coherent and linked. From the patient's perspective, it would be perceived as a smooth and coordinated progression of care (cited in Waibel et al. 2012).

Care Coordination—the deliberate integration of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health services, with continuity and fragmentation placed at opposite ends of the spectrum (Bodenheimer, 2008).

Care Transitions—healthcare services are continuously provided in a complex, loosely organized 'system', the potential for errors due to handovers and patient transfers—collectively known as care transitions is enormous (Hughes et al. 2007).

Transitions of Care—the movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change and may occur:

- Within settings (e.g. primary care to specialty care, or specialty care to ward)
- Between settings (e.g. hospital to sub-acute care, ambulatory clinic to seniors care)
- Across health states (e.g. curative care to palliative care of hospice, personal residence to assisted living)
- Between providers (e.g. generalist to a specialist practitioner, or acute care provider to a palliative care specialist)

According to the National Transitions of Care Coalition (NTOCC) Measures Work Group, transitions of care are a set of actions designed to ensure coordination and continuity. As such, transitions of care are a component of coordination (2008).

Transitional Care—a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care, includes both the sending and receiving aspects of the transfer, logistical arrangements, education of the patient and family, and coordination among health professionals involved in the transition (Coleman and Parry, 2003).

Interest in care transitions has grown in response to an aging population. Over time, countries have developed a vast array of services to meet the many and often complex health and social needs of older adults. The multiplicity of services involves many agencies, providers, settings and types of care in the delivery of care and services. Not surprisingly, several unintended consequences have emerged, including: lack of continuity and coordination between services, fragmentation of care, duplication of efforts, unnecessary delays and inappropriate use of costly resources (Coleman et al, 2004, Hollander et al, 2007, Kodner, 2006). Bodenheimer (2008) emphasizes the need for care coordination and describes the health care experience as a perilous journey. In a pluralistic delivery system, the number of providers, settings, and programs a patient encounters and transitions across is significant and contributes to the complexity and scope of the problem.

Much of the current understanding related to transitions in care has focused on transfers within acute care organizations or discharges from acute care to the home setting. It is known that transitions in care are highly sensitive to variations in context and are experienced differently by patient populations as they move across the health care system. Recently, more attention has been directed into looking at transfers from acute care to the increasingly complex domain of continuing care. Not only does this afford some important insights from a locality transition perspective, but continuing care subscribes to a different model and philosophy of care

(i.e. from a bio-medical or curative to supportive). The philosophy of care underpinning these two distinct models represents an important dichotomy. The majority of the population served by continuing care programs and services require long-term, non-acute care and supports. In general terms, the goal of care is not to cure a disease or condition, but rather to provide the necessary supports and services that decrease an individual's rate of decline, optimize and/or maintain functional capacity and promote positive quality of life (Hollander and Prince, 2002, 2008). The focus of care and the provider-client relationship are also distinctly different. A supportive model utilizes a holistic client-centered approach, respectful of the client and family expertise situated within the context of the environment where he/she resides versus a narrower, disease/disability focus. Personal and environmental safety is also viewed through this holistic lens, intended to foster and enable an individual's ability to function at their maximum capacity within their environment. Through this engagement and collaboration, the client and provider become partners in developing the plan of care, including the aspects related to safety. Jeffs et al. (2012) conducted and reported on a qualitative study that explored patients' and family members' perceptions on how safety threats are detected and managed across care transitions. The results revealed three key themes:

- Lacking information
- Getting 'funneled through' too soon
- Difficult adjusting to the shift from total care to almost self-care

With regard to this first theme, patients and families felt uninformed about their transfer were unsure about what to expect, including the time and location of the transfer, which created a sense of being overwhelmed. The second theme highlighted the patients' perceptions that they were inadequately recovered and/or not ready for a transfer, with the receiving facility or

organization unprepared for their admission. Lastly, the shift from receiving total care in the acute phase to managing their medications and increasing mobility with limited support was challenging. The respect and commitment for meaningful engagement with patients and families in enabling their active participation in care transition planning and self-care underlies the results as they represent the constants in the transition processes.

Seamless care—a smooth and safe transition of a patient from the hospital to the home. The term is frequently utilized in relation to the patient’s journey across settings, sites, clinicians and levels of care. In reality, the continuum of care that we refer to is a complex, often fragmented and discontinuous system that provides opportunities for systemic failure, errors and jeopardizes patient safety. Spehar et al. (2005) studied processes at the patient and organizational levels in two large facilities to identify factors that facilitate or impede seamless care from hospital to home. The qualitative analysis identified several themes focused on communication issues between patients and providers, providers and caregivers and between different providers. In addition, inadequate patient and caregiver education, limited or inconsistent continuity of care, inconsistent medical management, problems accessing needed services and lack of provider accountability featured prominently.

With health care resources strained, elderly patients are often discharged ‘quicker and sicker’ with chronic and/or terminal illnesses and are more vulnerable to errors and discontinuity of care. In recent years, with the advancement of technology and interventions, homes have increasingly become care centers where treatments are administered that were once confined to a hospital setting. Resource constraints and challenges regarding home health care services can help bridge this gap, but are not always available or appropriately utilized. Upon discharge, patients and their families are instructed to contact their primary care provider for follow up and

with any questions or concerns they might have. They are advised to return to the hospital (i.e. emergency department) in the event of experiencing deterioration in their health. This resonates of well-intended but ineffective advice given that often the primary care provider has not been involved in or informed about the hospital phase of care. The Strategic Plan for Northern Health (2009-2015) addresses the importance of integration and high-quality services built on the foundation of primary care and the primary care home. Central to facilitating the transfer of information and communication across settings is the use of information technology. The leadership team in Northern Health recognizes the importance of this information transfer between physicians and interprofessional teams across sectors, services and settings in contributing to better patient outcomes. With support from the Ministry of Health and in conjunction with the establishment of the Prince George Division of Family Practice in 2009, the executive team allocated resources and invested in the development and advancement of an effective electronic medical record (EMR). It is estimated that approximately 70% of family physicians have access to this system which enables connectivity across the region and continuum of care. More recently, the Chief Medical Information Officer outlined a major strategic project to facilitate the transformation of health care services entitled the Integrated Community Clinical Information System (ICClS). The requirements and drivers identified for this project include:

- Person/family centeredness—coordinated services, improved patient journeys and experiences, as close to home as possible;
- Clinician enabled—comprised of real-time clinical support, reduced multiplicity of paper and electronic records, built on a multidisciplinary team approach;

- Quality driven—improved population health outcomes predicated on research and evidence-based practice, which enables the creation of a complete record at point-of-care.

(Northern Health, PowerPoint Presentation, May 7, 2013)

The benefits of these developments and the strategic direction outlined and supported by leadership and the appropriate resource allocation are commendable. Arora (2009) emphasizes the importance of electronic health records as having the greatest potential to reform the way in which care transitions are accomplished while being cognizant that success will be contingent on local implementation. Most importantly, successful implementation and uptake regarding effective communication is reliant on a culture and a system that enable multidirectional interactive communication and accurately reflects existing care processes. In essence, the human functionality, interoperability and collective aim regarding quality care and transitions.

Integration and Integrated Care

Not surprisingly, these two terms are frequently used but are not readily understood or applied consistently in the context of health care. To further confound clarity, vertical and horizontal integration are also delineated. The following definitions are offered predicated on the belief that using health care resources more effectively and delivering better quality care may avert the care crisis that researchers, practitioners, policy-makers, administrators and consumers forecast. A number of assumptions are embedded in how this terminology is applied and interpreted based on varied stakeholder perspectives.

Vertical integration—describes a situation where different components of a supply chain are brought together in a single organization; within the context of health care two main types exist:

where agencies involved at different stages of the care pathway are part of a single organization or where payer and provider agencies are part of a single organization (Ramsay et al, 2009).

Horizontal integration—similar organizations/units at the same level join together

Integrated care—a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion

Integration—is a means to improve services in relation to access, quality, user satisfaction and efficiency (Grone and Garcia-Barbero, 2002, cited in Ramsay et al, 2009).

Terminology plays a key role in how we think about, shape, deliver, manage, regulate, finance and evaluate health care. Kodner and Spreeuwenberg (2002) deconstruct the ‘roots’ and intentions of integration. Integration originates from the Latin verb *integer*, ‘to complete’. Integrated means ‘organic part of a whole’ or ‘reunited parts of a whole’. In other words, the bringing together of elements that were previously separate. The definition they propose is more inclusive, patient-centered and underlies a supportive model of care: a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these models is to enhance quality of care, quality of life, consumer satisfaction and system efficiency for patients with complex, long-term problems cutting across multiple, providers and settings. Defined in this way, integration requires cooperation and collaboration among various part of the system and/or organization--the ‘glue’ that bonds the entity, enabling it to achieve common goals and optimal results.

The multitude of definitions has become problematic, comprised of a bewildering range of vague and unclear terms. Howarth and Haigh (2007) describe it as a ‘quagmire’ of definitions

and concept analyses. These authors attribute the elusiveness of ‘seamless service’ strived for by many in health care to the conceptual ambiguity of integration and suggest conceptual clarification would support the development of services and enhance the quality of patient care.

Integrated care has become a global ‘buzzword’ and a key concept that has changed major policy and practice-level changes in health systems in North America, Europe and other parts of the world for more than two decades. It has been posited as a demand-driven response to what ‘ails’ healthcare, namely: access issues, fragmented services, sub-standard quality, system inefficiencies and cost pressures. Superimposed on the above problems is the dichotomy that exists between the complex needs of frail elderly and people with chronic disabilities and conditions and the system’s steadfast reliance on an acute bio-medical model of care.

The focus on, interest in and aspirations regarding health care transitions and integrated care seems appropriate given our aging population and the rapid growth of chronic and terminal diseases. Collectively, these factors and the current strain on the system drive the need to pursue better ways to deliver health care. Our fascination with the concept seems defensible as we endeavour to develop the ideal model to sustain health care. Looking to integration as a means of using resources more effectively and delivering better quality care represents the possibility and a shared vision for health care providers, organizations, administrators, funders, politicians and governments. Johnson (2009) advises that if we are “to join together to accomplish a solution to the health care problem, an understanding of the terminology would be useful” (p. 704). This sentiment is echoed by many throughout the literature and in practice.

Health systems and health care organizations are complex and interdependent entities. However, a number of factors have contributed to the divisions in organizations and services on

one hand and administrators, physicians, nurses and allied health professionals on the other, some of which include: differing rules and regulations, inter-sectoral boundaries, funding streams, and institutional and professional cultures (Kodner and Spreeuwenberg, 2002). Health care access, delivery and quality suffer. Most importantly, patients and their families experience gaps or delays in care, increased anxiety and loss of confidence in providers, the system and negative outcomes---lost on a ‘perilous journey’.

Integration does not require that all parts of the health system are completely merged. Integration can be seen as an important step in the process of health systems and health care delivery becoming more comprehensive and effective. A patient-centered approach based on population needs in redesigning care and services is foundational in order to attain improved outcomes and quality of care.

Kodner (2009) characterizes integration as a nested concept, comprised of five dimensions:

- Foci of integration: entire communities or populations, vulnerable client sub-groups or patients with complex or chronic illness
- Types of integration: functional, organizational, professional, service or clinical, normative and systemic
- Levels of integration: funding, administrative, organizational, service delivery and clinical (aligned with types above)
- Breadth of integration: horizontal and vertical
- Degree of integration: linkage, coordination and full integration

In addition to the multitude of definitions about what integration means, a bifurcated or two-pronged approach has been developed as follows:

- A ‘top-down’ hierarchical approach that focuses on the generalized organizational desire, driven by processes, to achieve perfection and optimization versus
- A ‘bottom-up’ approach that is patient centered and attempts to use characteristics and needs of defined patient groups as the ‘blueprint’ for determining the fit of the existing systems and how systems need to be integrated to optimize care (Thaldorf and Liberman, 2007).

Although there is an abundance of literature and models in existence, there is not a ‘one-size fits all’ model or process for successful integration. In addition, there is a paucity of empirical evidence for specific integration strategies, processes and demonstrated outcomes at the system, program, provider and client levels. Armitage et al (2009) conducted and reported on a systematic literature review from the health sciences and business databases and grey literature and found there was a lack of quality studies providing evidence on how health systems can improve service delivery and population health. Paradoxically, integrated systems have been promoted as a means to build a more effective and efficient health care system, using a patient-centered approach to better meet the needs of the populations served. Decision-makers and leaders are challenged in their quest to find comprehensive evidence-based information while pressure mounts to effect change within the current context.

In the absence of substantive evidence to guide the planning, implementation and evaluation of integrating health systems and the realization that a one-size-fits-all solution is non-existent, some key principles and ‘laws’ are provided to inform the approach. The ten principles connected to successful processes and models are summarized by Suter et al. (2009):

1. Comprehensive services across the continuum of care—responsibility to plan for, provide, purchase and coordinate all core services along the continuum for the population served, from primary to tertiary care and collaboration between health and social care organizations
2. Patient focus—the impetus for integrated delivery systems is to meet the patients’ needs versus the providers’ needs, to ensure the patient receives the right care at the right time
3. Geographic coverage and rostering—to maximize patient access to services and reduce duplication
4. Standardized care delivery through interprofessional teams—a basic tenet of integration with communication channels that transfer information across organizational boundaries
5. Performance management—protocols and procedures for measuring care processes and outcomes related to quality and cost
6. Information systems—information can be accessed from anywhere in the system to facilitate communication between care providers
7. Organizational culture and leadership—leadership with vision, a supportive care philosophy and population health focus
8. Physician integration—physicians need to be integrated at all levels of the system and provide leadership in the design, implementation and operation
9. Governance structure--diversified with representation from a variety of stakeholder groups that understand delivery across the continuum
10. Financial management—mechanisms that accommodate pooling of funds across services

The principles discussed above are applicable to the Canadian context and can assist leaders, decision-makers, providers and clients in focusing and guiding integration efforts while acknowledging the need for organizational flexibility and adaptability at the local level.

The ‘laws’ for integrating medical and social care were first authored by Leutz in 1999 and propose:

- You can integrate some of the services for all the people, all the services for some of the people, but you can’t integrate all the services for all of the people
- Integration costs before it pays
- Your integration is my fragmentation
- You can’t integrate a square peg and a round hole
- The one who integrates calls the tune

(cited in Leutz, 2005).

In a more recent publication of 2005, he puts forward three simple and important questions:

1. Why is integration so difficult?
2. Can we make it any easier?
3. What other guides for integration exist?

The examples reported on in the United Kingdom, Europe and the United States demonstrate some successes, but also illuminate some significant challenges. Rayner (2009) points out that integration within the system does not necessarily require the merger of organizations but needs new thinking about the way in which resources are utilized and controlled—integration is not about pooled budgets or cutting costs. In a system where services are interdependent, it is logical to manage them in a coordinated way with the astuteness that changes in one part of the system

have consequences for the remainder. Three levels of integration have been identified and are delineated as follows:

1. Linkage—health and social care providers work together more closely, but still function within their respective silos (i.e. rules, policies and funding streams)
2. Coordination—involves a rebalancing of the system to bridge gaps between services and users and helps to reduce confusion, miscommunication and lack of information-sharing without redesigning the whole system
3. Full integration—combines responsibilities, resources and funding for long-term care from multiple sources under one, creating global financing, management and unified service delivery (Kodner, 2006).

One model of a fully integrated approach called the Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) operates in Quebec. The focus is the coordination of medical and social care for the frail elderly. Agreements with provincial and private social care agencies were negotiated and required that the participating agencies use a standardized assessment form, administered at a single point of entry, with a common clinical chart and care plan. The use of an electronic record facilitated communication between the teams and organizations. The PRISMA model has been generalized across the province, merging public hospitals, long-term care facilities and home care agencies under single organizations with a region, organized in 95 health and social service centres across the province (Health Council of Canada, 2012).

In the United States, the Program of All-inclusive Care for Elderly People (PACE) provides acute and long-term care services which are coordinated by and organized around an

adult day center. The program is targeted to community-dwelling elderly people aged 55 years and over who are eligible for nursing home admission and covered by both Medicare and Medicaid. Informal caregiver involvement is emphasized. PACE initially operated as a federal government demonstration program between 1987 and 1997. It has since become a permanent provider under the insurers operating in a number of states throughout the U.S. The National PACE Association described the typical participant as similar to the average nursing home resident: female, 80 years old, has 9.7 medical conditions, is limited in approximately three activities of daily living, and likely has been diagnosed with dementia (i.e. 49%) (National PACE Association, 2005). Qualitative and quantitative evaluation studies conducted in 1992 and 1998 found the model to be effective as an integrating mechanism which has been attributed to the intense geriatric focus, use of the geriatric day center as a combined setting for primary medical care, health, social and supportive services and the team-based clinical coordination and continuity of care.

Integrated home services in Denmark illustrates the importance of bringing new thinking, with appropriate legislative, policy and funding supports into program development and practice. In 1987, Denmark stopped building new long-term care facilities and re-focused legislation and resources on enhancing home care and assisted living. The home care programs comprise: nursing care, meals, home adaptations, day care, financial assistance, transportation and 24-hour access to services. These efforts have demonstrated cost-effectiveness when compared to long-term care facilities. To augment the supports available to encourage a 'home is best philosophy' and remain independent for as long as possible, seniors are provided service alternatives that allow patients and their families to select the services they need and prefer. The integration and coordination is achieved through: case management, interdisciplinary teams, cross-setting care

and common training programs. Another important aspect is key—leadership with a broad and integrative focus to create the necessary linkages, connections and conditions that support a new way of working and transform social network structures (Avolio, 2007).

The terminology, application and understanding of these key concepts has not garnered consensus as the conceptual definitions, explicit processes and structures remain varied. Johnson (2009) characterizes this reality as representing the elephant in the room and questions what health care should look like to best serve the population and provide more than the treatment of disease? There are many determinants of health. It is recommended we look beyond the practitioners and professions and include the systems and the people care is intended to serve. One message consistently expressed throughout the evidence that resonates—value and embed the patients’ and families’ experiences and perspectives in the quest for better health outcomes.

Patient/Family Centered Care—From Rhetoric to Reality?

As previously discussed, care transitions present major threats to patient safety and care quality. Transitions refer to the movement of patients between healthcare providers and between settings and across the whole healthcare system. The current state of care transitions is unsatisfactory, negatively impacting patient satisfaction, quality and safety, and increasing health care costs. The magnitude of the threat due to poorly managed transitions is significant given the number of people accessing care and services and the volume of patient movement activity within the system. In 2009, the World Health Organization identified lack of communication and coordination to be the top research priority for developed countries (cited in Singh et al. 2011). Recidivism rates within 30 days of discharge from hospital have been identified as a proxy for failure in the transition from hospital to home. These rates are high and continue to grow

(Coleman, 2003; Coleman, et al. 2004; Spehar et al. 2005). In addition, better outcome measures related to the frequency and type of errors and safety climate specifically related to transitions would be beneficial for all stakeholders invested in improving quality, safety, efficiency, coordination and population health outcomes.

The issues related to transitions are not confined to Northern Health or any one jurisdiction. The prevalence of research, reported studies and discourse about these concepts are indicative of a global concern. Previously, the focus on discharge planning and the processes that enable timely and expedited discharges from hospital has led to mixed improvements but has not resolved many of the key issues. In the academic literature, patient and family perspectives about care transition interventions are surprisingly absent. Perhaps a rethink by researchers, policy makers, decision-makers and program developers regarding the value related to meaningful inclusion is necessary to achieve the desired results.

A shift in thinking is evident in the significant and expanding trend regarding the need to include patients and their families in reforming healthcare delivery and policy. A recently published white paper by the National Health Services (NHS) Department of Health in 2010 identified 3 key objectives underlying their approach:

- To put patients at the heart of everything the NHS does;
- To focus on continuously improving those things that really matter to patients—the outcome of their healthcare;
- To empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services.

Incorporating these 3 objectives as a framework to guide the improvement of care transitions, coordination between providers of different disciplines and settings, and care will, these study authors argue, enable patient and family experiences to assume a central role as a key indicator of quality. It is apparent that developing a better understanding regarding patient and family views could inform the development and implementation of new strategies for redesigning services. Adopting a robust patient-centered approach could lead to improvement in health and social outcomes, improvement in self-care capabilities through education conversation, and empowerment during future encounters with the system. One of the studies reviewed evaluated patient perspectives regarding the importance of different components of a care transition which affirmed these findings (Cawthon et al, 2012).

The evidence confirms that persons with long-term, continuous and/or complex care needs require care in a multitude of settings. It is during these transitions that this population becomes especially vulnerable to experiences of poor care quality and fragmentation. There are multiple points during a transition at which care processes can break down. Unfortunately, patients and family members are often ill-prepared to navigate the complexity and challenges within the system. Carr (2007, 2008) summarizes these main areas of concern which include: transitions or hand-offs of care, medication reconciliation, patient/caregiver education, access to the right services at the right time and timely and effective communication. The experience and assessment of the current state by the Health Service Administrator in Northern Health corroborates these findings.

To demonstrate the importance of developing interventions designed to actively involve patients and their families, a study was conducted and reported by Coleman et al (2004). The setting consisted of a large not-for-profit integrated delivery system in Denver, Colorado which

provides care for more than 56,000 patients aged 65 and older. The delivery system contracts with a hospital, eight skilled nursing facilities and a home health care agency. The goal of the intervention was to improve care transitions by providing patients and their caregivers with tools and support to actively participate in the transition from hospital to home. The intervention encompassed four key areas: medication self-management, a patient-centered record, primary care and specialist follow-up and knowledge of ‘red flags’ or warning symptoms of a worsening condition. In this study, hospitalized patients who received the patient-centered intervention designed to enhance their role in managing transitions were approximately half as likely to return to the hospital. The patients reported increased confidence in obtaining essential information, communicating with the interdisciplinary team and understanding their medication regime. This patient-centered intervention filled an important gap in care transitions. This type of approach is congruent with regional, provincial and national directions aimed at supporting patient-centered care, coordination, quality and safety, and cost control while moving away from a provider or operational centric focus.

The relationship between continuity and patient satisfaction has frequently been studied and reported in the literature. Continuity of care has been considered to be a core principle of family medicine and primary care, but conclusive proof regarding its value has been elusive. Saultz and Albedaiwi (2004) systematically reviewed 142 articles that addressed this component. These physicians reported that although research limitations were present due to differing definitions and measurement techniques, interpersonal continuity matters to patients and their primary care providers. A consistent significant association between continuity of care and patient satisfaction was also noted.

Process Mapping

The information presented throughout this paper aims to inform an evidence-based approach to care transitions and integration. The framework would be incomplete and we would be remiss in our efforts if we did not pursue a better understanding of the patient and family perspectives. Healthcare process mapping is a relatively new, versatile and simple technique that can be utilized to examine, understand and incorporate the patients' (and their respective families') perspectives. These salient perspectives contribute valuable information to assist leaders and health care teams in their quest to identify problems and provide recommendations for service and care delivery improvement. Process mapping enables us to 'see' and develop a more robust understanding about the patient's experience by separating the management of a specific condition or treatment into a series of consecutive events or activities (e.g. activities, interventions, staff interactions, etc.). The sequence of the steps between two points can be viewed as a pathway or process of care. To illustrate this technique, two patient journeys previously conducted in 2012 as part of the project entitled *Integrated Care for Seniors in Prince George* are appended to this paper (see Appendices A and B). The data provided by process mapping can be utilized to redesign the patient pathway to improve both the quality and efficiency of clinical care management and to shift the focus of care towards activities most valued by patients and families. This type of process mapping has demonstrated clinical benefits across a variety of specialties, interdisciplinary teams and health care systems. The NHS Institute for Innovation and Improvement highlights a range of advantages to incorporating this approach which include:

- A starting point for an improvement project specific to a local context
- Creating a culture of ownership, responsibility and accountability

- Illustrating a patient pathway or process, understanding it from the patient's perspective
- Assisting in planned change
- Collecting ideas that engages patients, their families and providers
- An end product (process map) that is readily understandable and visual

(Trebble et al, 2010)

As previously discussed, the NHS has commissioned numerous studies, reports, audits, publications and the implementation of social and health policy reforms to support a more responsive, patient-centered system. This work has included broad and extensive consultation with all levels of government, patients and their families, the general public and external organizations. The aim and focus of the work has promoted health care teams across a variety of services and sectors to “move from a service that does things to and for its patients to one which is patient-led where the service works with patients to support them with their health needs” (Department of Health, 2005, cited in Pickles et al, 2008). Clinical governance and leadership are deemed to be foundational for improving the quality of services delivered and fostering an organizational environment where excellence in care can flourish. These authors assert that health care services have a long way to go before they can declare that they are actually putting patients first.

The challenges and complexities that exist in practising organizational leadership are numerous. Bennis (2007) emphasizes the importance surrounding and the complexity of leadership in relation to contemporary theories and studies. This author argues that a single unifying theory of leadership may not be achievable when consideration is directed to several salient factors: the vastness of the topic, the amorphous and ‘slippery’ nature of the concept and

its importance in effecting change in complex systems. To illustrate the conundrum inherent to the practice of leadership, the following example is offered. In Northern Health, the demand for orthopedic surgery is growing beyond the region's capacity to provide the services necessary within the Ministry of Health's mandated fifty-two week elective surgery wait time benchmark. The government has stipulated performance measures for all elective surgeries, upon which the allocation of funding is dependent. As a result, the Ministry of Health has withheld a portion of the health authority's annual budget. The actual funding the health authority will receive will be based on performance at the end of fiscal periods 3 and 4. Not surprisingly, some of these surgical procedures are costly. A number of competing priorities and interests are at play, some of which include: human resources and program capacity, the required deliverables in a 'pay for performance' funding model, a climate of fiscal constraint, the increasing demand for these procedures within the region, the political environment and the patient-centered approach related to timely quality care. This scenario illustrates the difficulties that arise and the dichotomies which exist in today's organizational reality which are outside of the individual leader's locus of control, are problematic, and must be attended to. The following section reviews some of the prevailing and emerging leadership theories, Northern Health's espoused theory and practice philosophy and the value proposition of leadership in patient-centered integrated care.

Leadership and Leading the Whole Continuum of Care

There is an abundance of theories, studies and literature of the concept of leadership, mainly located within the scientific paradigm of logical empiricism or positivism. In spite of the proliferation of empirical studies, theoretical work and numerous publications, the phenomenon

of leadership is not clearly understood. There is growing discontent, interest and evidence provided by a number of researchers and authors that challenge the prevailing objectivist approach to leadership studies (Lakomski, 2005; Alvesson and Sveningsson, 2003; Gronn, 2000). My examination of this topic has prompted me to question the mainstream thinking and to explore other paradigms, ideologies and conceptual models that contribute to and enhance understanding of how people relate to, talk about and practice leadership.

My exploration and review of the literature to date and the books authored by Lakomski (2005) and Alvesson and Spicer (2011) have catalyzed the development of a more critical and contextual view of leadership. Lakomski (2005) and other authors challenge what is traditionally and habitually described in the leadership literature. Alvesson and Sveningsson (2003) assert that “it seems very difficult to identify any specific relationships, behavioural styles, a coherent set of values, or an integrated coherent set of actions that correspond to or meaningfully can be constructed as leadership as important and intended (cited in Lakomski, 2005, p. 3). These authors argue that much of what is identified in the literature supports the ever-growing discourse on leadership, which speaks to the popularity of leadership, but in reality, is ‘no proof of anything’. Emphasis is placed on the need for us to approach the traditional models of leadership with a healthy amount of skepticism and move away from an unquestioned acceptance that adding leadership to a complex situation will automatically resolve organizational challenges.

The focus evident in the literature and in leadership studies is characterized by an interest in identifying variables and factors that would determine a leader’s essential nature. The initial work revolved around the identification of a single trait theory that would account for leadership. The research related to single-trait/unitary-trait theory was not successful. As a result, the focus

was broadened to include the identification of multiple traits deemed essential in leaders and was referred to as the constellation-of-traits-theory. Numerous empirical studies, conducted using quantitative methods, were applied in an attempt to provide empirical data which would enable generalizations to be made across organizational contexts, thereby creating good leaders and efficient organizations. The aims of this research were also not achieved. Yukl (1989) describes leadership as being “in a state of ferment and confusion. Most of the theories are beset with conceptual weakness and lack strong empirical support. Several thousand empirical studies have been conducted on leadership effectiveness, but most of the results are contradictory and inconclusive” (cited in Alvesson and Sveningsson, 2003, p. 362).

One of the more perplexing findings in all that has been studied and reported in the literature is the lack of consensus around the conceptual definition of leadership. It is suggested that what is known about leadership is fragmented and open to subjective and contradictory opinions. As such, the ‘essence’ of leadership remains elusive. Lakomski (2005) related leadership to beauty, as it resides in the eyes of the beholders versus a clearly identifiable construct.

My examination has taken me beyond the models developed by Bass (1985) and Burns (1979) and their theories of transformational and transactional leadership styles intended to help us understand and advance a paradigm of effective leadership. Spinelli (2006) states “responsible and appropriate leadership is critical to the success of any industry. Leadership in the healthcare environment today is essential and mandated if our healthcare system is to survive” (p. 11). One of the shortcomings inherent with this view is the continued reliance on the individual traits of the formal leader, without sufficient attention to other salient elements such as culture, context and followers. The leader is part of the culture and cannot step out of him/her self. It is widely

recognized that an organization's culture is an important element in understanding and contributing to organizational functioning and performance.

Organizational culture cannot be understood in the absence of environmental or situational factors. The interdependencies, relationships, power dynamics and communication networks embedded in organizations cannot be dismissed. The context, an ever-changing landscape, makes it challenging for leaders to 'connect the dots' in practice and when operationalizing strategic directions and initiatives. The need to move beyond trait theories and competencies to a more dispersed or distributed model is suggested based on the evidence that reveals there is no direct causal link between the leader, culture and organizational change. Lakomski (2005) proposes the "idea of dispersed or distributed leadership, as currently gaining ground in organizational theory goes a long way towards debunking the leader myth of traditional leadership theories in attempting to account for situational and contextual factors" (p.14). I endorse the view that culture is *not* a thing, but is unfolding and evolving as a result of human experiences and interactions over time. This perspective advances a view of leadership as a process, with more of a focus on the complexities of context, situational functioning and practice. Pearce and Conger (2003), in their publication *Shared Leadership: Reframing the Hows and Whys of Leadership*, depart from the traditional view of leadership as being something imparted to followers by a leader with positional authority and propose that leadership comes from the relationship that is produced by both leaders and followers.

Additional evidence and endorsement is offered by Alvesson and Spicer (2011). These authors report that leadership is a complex and contradictory phenomena. In their recent publication, *Metaphors We Lead By: Understanding Leadership in the Real World*, they explore the ambiguities, paradoxes and incoherencies associated with leadership. They highlight the

dangers in the existing generalizations written about leadership: “we begin to see almost anything and everything as leadership” (p.9). It is acknowledged that for different groups, leadership may have different meanings and values. By accepting a more ambiguous and skeptical approach to leadership, the opportunity to see how leadership is enacted, interpreted and responded to in the real world is created. Leadership is seldom self-evident and clear-cut. Therefore, a range of diverse ideas facilitates a deeper understanding of the concept. Alvesson and Spicer (2011) use metaphors as a method of capturing the variation, complexity and ambiguity of leadership. Six metaphors are utilized to illustrate the multitude of possible meanings and include: saint, gardener, buddy, commander, cyborg and bully. These six metaphors and corresponding themes are summarized in the following:

- moral peak performance—the leader as a saint-like figure provides moral guidelines and relations high on trust;
- support with personal growth—the leader as a gardener helps people improve themselves, increasing competencies and self-confidence;
- creating a cosy work climate—the leader as a buddy produces an attractive workplace where people feel good about themselves and others;
- setting direction—the leader being a commander, creates clarity and a powerful example for others to follow;
- underscoring rationality and efficiency—the leader as a cyborg, standing for machine-like efficiency bringing about the delivery of results;
- providing sanctions, including intimidating people—the leader underscoring the norms and keeping up standards through bullying those seen as not contributing enough or doing what the leader thinks is best.

Leaders and followers are encouraged to consider each of these metaphors when trying to enact leadership or understand how leadership is exercised in a range of situations in real life.

Alvesson and Spicer (2011) highlight the influence of the broader social context as another source contributing to the ambiguity regarding leadership. Tension often exists between how leaders enact their role, how they perceive themselves and the contexts in which they lead.

Leaders are expected and/or required to embody the norms of their positions and influence others in ways that are consistent with their normative obligations. In reality, a range of diverse understandings about leadership exist in organizations between leaders and followers.

Periodically, a misalignment occurs between what leaders think it means to lead and what the followers envision leadership looking like. The metaphors provoke new ways of thinking about leadership, including those aspects that might be referred to as the 'darker sides' of leadership.

Currently, much of what is written and discussed about leadership portray the construct in a positive light. This almost sacred portrayal needs to be challenged. Leaders, as mere mortals, are impacted by the tensions, inconsistencies and insecurities which exist in the everyday organizational reality.

Leadership researchers have argued that an important way that leaders manage meaning is through crafting the 'culture' and language that is used within an organization. An important aspect of this management of meaning is apparent in how leaders use discourse in day-to-day practices of leadership. For instance, the Interim Health Service Administrator, responsible and accountable for the *Integrated Health Care for Seniors in Prince George Initiative*, has crafted a key message which highlights the need to move "from managing within, to leading transitions in care, to leading the whole continuum of care" (Northern Health, March 2013, see Appendix C). She asserts that a transition is more than a response to a change in circumstances. The new

set of circumstances requires that an individual and/or the designated leader respond in some manner—the key is to respond differently than previously. In this model, both the new circumstance and the manner in which it is responded to require attention. This leader describes the approach as “leading the background orientation”. The ‘whole versus parts’ premise was incorporated into the redesign of care for seniors using the metaphor of ‘parts of a tree and growing a tree’ (see Appendix D). The importance of preparing the organization and establishing the conditions for growth and sustainability are emphasized in the model. The leadership component is about leading conversations that establish a new culture of care and orientation to care (Northern Health & Armstrong Consulting Group, 2012). The approach taken up by this leader in response to the challenges inherent in contemporary health care is unique, but shares several commonalities with the non-traditional theorists’ views, such as: collective/dispersed versus single-trait theory, the relational aspect of leaders and followers, and organizational culture. Moving beyond the five dimensions of integration previously discussed, leading a change in culture represents a ‘deeper dive’, described above as leading the background orientation.

Leading transitions in care is necessary, but insufficient in building a collective patient-centered approach and new organizational culture. Leaders must embrace and demonstrate visible connections through collaboration and authentic, transparent communication that engages providers and recipients of care and service across sectors, professions and geography. In essence, the leader endeavours to connect the providers with the whole continuum of care versus the pieces they are assigned to, responsible for or employed within. Organizational silos, disciplinary boundaries, hierarchical structures, turf protection and a bio-medical orientation to

care have inculcated leaders and followers to treat and manage the pieces. The ‘work of leadership’ to achieve and/or exceed quality care and service outcomes is discussed below.

The notion of deconstructing the traditional views of the leader-follower relationship is daunting, yet foundational in supporting a new way of thinking. Heifetz and Laurie (2001) disrupt the conventional thinking on this subject. These authors refute the leaders as shepherds metaphor protecting their flock from unpleasant surroundings. Conversely, they propose that followers are exposed to their sometimes painful realities and circumstances. Subsequently, leaders must insist that the followers endeavour to formulate a response or strategy. This concept, termed adaptive change, cultivates emotional fortitude in followers. It is reported that the ability to adapt to change in a highly competitive and often contentious environment is critical. In order to make change happen, leaders need to break their habituated patterns of providing leadership in the form of solutions. These authors argue that solutions to adaptive challenges do not reside with the executive leaders, but in the collective intelligence and abilities of employees (followers) at all levels in an organization. This is key as the locus of responsibility for problem solving when facing adaptive challenges must shift to the followers. In addition, adaptive change is distressing for those experiencing it. It may require acquisition of new roles, values, behaviours, relationships and/or approaches to work. These authors dispel the need to orientate followers to their new roles. In contrast, they recommend leaders must disorientate followers to enable new relationships to develop. With this approach, quelling conflict is counterproductive. Leaders have to draw out the issues and challenge ‘the way we do business’ to move forward and away from historical or traditional practices. The six principles proposed for leaders in leading adaptive work are summarized:

- get on the balcony—see a context for change or create one;

- identify the adaptive challenge—acknowledge that the team reflects the best and worst of the organization’s values and norms, which provides insight into the type of adaptive work going forward;
- regulate distress—maintain a productive level of tension, sequence and pace the work, raise difficult questions without becoming overly anxious and tolerate, uncertainty and discomfort;
- maintain disciplined attention—innovation and learning are products of diversity fostered by listening to and consulting one another as resources
- give the work back to the people—learn to support versus control and enable workers to take responsibility and develop self-confidence;
- protect the voices of leadership from below—give a voice to all people and avoid the impulse to neutralize contradictory perspectives and restore equilibrium.

In summary, these authors view leadership as needing to embrace an ongoing learning strategy that includes: engaging people in confronting challenges, adjusting values, changing perspectives and learning new habits. Leadership, by virtue of its existence in organizations, is called upon everyday when implementing strategies and confronted with adaptive challenges and change.

The previous discussion on leaders and the management of meaning and discourse within an organization is expounded on by Foldy et al. (2008) in their conception of the cognitive shift that is necessary to enact the work/role of organizational leadership. Their extensive review of the leadership and social movement literature created a way to move beyond the individual characteristics and behaviours and focus on organizational processes. The concept of cognitive shifts is introduced and defined as a building block concept, which includes: a change in how an organizational audience views or understands a key element of the organization’s work or a

change in mental frame or mental model. They describe cognitive shifts as the desired outcomes of sense-giving. Sense-giving is about shaping how people understand themselves, their work, and those engaged in the work as critical. They acknowledge that leaders do not have an unlimited capacity to shape their messages. Framing is a key element and is enabled and constrained by both internal and external forces, such as: prevailing norms and values, accessibility of different discourses and understandings, the organization's financial and material resources, and the frames of allied and competing organizations and interests. Their views are congruent with a more dispersed or distributed model of leadership, which sees leadership as the property of a collective versus an individual. They assert that the construct of shared leadership and the work of meaning-making hold remarkable opportunities for future research.

Conclusion

My examination of these three fascinating, complex and interrelated concepts has been a journey and a 'work in progress' over several years. The journey has been challenged by factors outside of my locus of control and interrupted at several points along the way. However, my curiosity, enthusiasm and tenacity to complete the program and produce a product (paper) that reflected the academic, leadership and experiential knowledge gained was not deterred. The ongoing support, encouragement and counsel provided by the University of Victoria, Faculty of Graduate Studies, the School of Nursing, the Dean of Human and Social Development and the Interim Health Service Administrator, Prince George have enabled me to resume and maintain the path towards successful program completion for which I am very grateful. Much like transitions, integration and leadership, the experience has been complex, enlightening and confusing, and fraught with challenges and opportunities for growth and learning.

My career in health care, spanning approximately twenty-five years, in a variety of roles, settings and sectors has afforded me numerous positive experiences and opportunities, and has assisted me in the development of a broad view of care and service delivery across sites, regions and the province. The experiences of leadership and leader-follower relationships, both as a leader and follower, have comprised both the positive and darker sides of leadership as reported in the literature. Through the exploration of the research/evidence, my endorsement of and congruency with the non-traditional theorists has grown. The use of metaphors to make sense and give meaning to the concept of leadership with its acknowledged ambiguity has helped me construct new understandings and strategies to negotiate the ‘murky’ waters of leadership. Alvesson and Spicer (2011) recommend we set aside judgement and moral assessments about metaphors and leadership and accept that leaders are not all good or all bad, and sometimes a paradoxical mix of characters. This notion is key for the creation of new mental models and the acceptance of the tensions and inconsistencies that accompany leadership in today’s organizational realities.

Lakomski (2003) provided a strong foundation from which to build on in moving beyond trait theories to more contemporary post positivist models. This author acknowledged and emphasized the importance of situational, contextual and cultural factors and leadership. This perspective resonated with my experiences in practice, produced by both leaders and followers in everyday organizational life. The lack of conceptual strength and empirical rigour reported by numerous studies on leadership and leadership effectiveness was problematic—an unanticipated discovery for me. This realization disrupted a largely unquestioned acceptance formerly held regarding empirical studies.

The concepts related to care transitions and integration illustrated the vast and confusing array of conceptual frameworks, approaches and discursive structures. In resemblance to the concept of leadership, the idea of integrating health care services has become a sort of ‘panacea’ for all that ‘ails’ health care services, quality and patient safety. Integration has been applied to a variety of different problems, driven by a range of often divergent and competing interests, with mixed success. The multiplicity of obstacles and frustrations for those willing to move the integration agenda forward need to become fully informed regarding the inherent complexity and the deeper political, economic and social changes it creates. History, habit, tradition and silos in organizations are difficult to change or deconstruct. Transformational change is required at many levels to bridge the gaps across the existing structures and move beyond the popular ‘buzzword’ in an effort to improve service and care provision.

A number of common themes and contradictions were revealed through the examination of these important and interrelated concepts namely, care transitions, integration and leadership as illustrated in Table 1.

Table 1

Common Themes and Contradictions

Common Themes	Contradictions
A proliferation of research	Used inconsistently with many interpretations and applications
Complex, multidimensional and difficult to define	No ‘roadmap’ for what ‘ails’ health care
An abundance of interest, discourse and focus across sectors	Limited research to evaluate implementation and impact
Aim to improve care quality, communication and connectivity	Lack of conceptual clarity, definitions and models
Focus on patients/families versus providers and organizations	Lack of systemic understanding and application Lack of patient/family perspectives included in research studies

The principles proposed by Armitage et al (2009) and the ‘laws’ outlined by Leutz (1999; 2005) formulate a framework to advance the work surrounding care transitions and integration. The need for improved coordination and communication across primary and secondary services, that incorporates the patients’ and families’ perspectives as the organizing principle, is imperative. To achieve this type of substantive change, vertical and horizontal integration must proceed in a synchronous manner to be adaptive and successful (Thomas et al, 2008). Significant cultural and cognitive shifts are required---the clients’ health and experiences of care rather than

the functions of providers, decision-makers and the prevailing political will. Leadership is essential for creating the shared vision and articulating the principles and framework for integration and beyond—disrupting the conditions in organizations and orientation to care in order to construct a collective aim across the continuum. Nurse leaders are well positioned to make a significant contribution to patient-centered care and integration by drawing together the strands of the management of care systems, cross-boundary working and thinking and the effective allocation of resources. Much work lies ahead in view of the attendant challenges. There is a long way to go in healthcare to put clients first and actualize this important and ambitious vision.

References

1. Alvesson, M. and Spicer, A. (2011). *Metaphors We Lead By: Understanding Leadership in the Real World*, Routledge: New York.
2. Alvesson, M. and Sveningsson, S. (2003). The great disappearing act: difficulties in doing leadership, *The Leadership Quarterly*, 14, p. 359-381.
3. Armitage, G., Suter, E., Oelke, N. and Adair, C. (2009). Health systems integration: state of the evidence, *International Journal of Integrated Care*, June, p. 1-11.
4. Arora, V. (2009). Tackling Care Transitions: Mom and Apple Pie vs. the Devil in the Details, *Journal of General Internal Medicine*, 24(8), p. 985-987.
5. Avolio, B. (2007). Promoting More Integrative Strategies for Leadership Theory-Building, *American Psychologist*, 62(1), p. 25-33.
6. Bennis, W. (2007). The Challenges of Leadership in the Modern World, *American Psychologist*, 62(1), p. 2-5.
7. Berwick, D. (2002). A User's Manual for The IOM's 'Quality Chasm' Report, *Health Affairs*, 21(3), 80-90.
8. Bodenheimer, T. (2008). Coordinating Care—A Perilous Journey through the Health Care System, *The New England Journal of Medicine*, 358 (10), p.1064-1071.
9. Botwinick, L., Bisognano, M. and Harden, C. *Leadership Guide to Patient Safety*, IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2006.
10. British Columbia Newsroom, B.C. Government Online News Source, March 1, 2013, *B.C. Continues to Expand Primary and Community Care*;

<http://www.newsroom.gov.bc.ca/2013/03/bc-continues-to-expand-primary-and-community-care.html>.

11. British Columbia Newsroom, B.C. Government Online News Source, February 22, 2013, *Government and Doctors Partner to Improve Primary Care*; www.newsroom.gov.bc.ca/2013/02/government-and-doctors-partner-to-improve-primary-care.html.
12. Carr, D. (2008). Effective Care Transitions, *Nursing Management*, January, p. 25-31.
13. Carr, D. (2007). Case Managers Optimize Patient Safety by Facilitating Effective Care Transitions, *Professional Case Management*, 12(2), p. 70-80. Cawthon, C., Walia, S., Osborn, C., Niesner, K., Schnipper, J. and Kripalani, S. (2012). Improving Care Transitions: The Patient Perspective, *Journal of Health Communication*, 17, p. 312-324.
14. Cawthon, C., Walia, S., Osborn, C., Niesner, K., Schnipper, J. And Kriplani, S. (2012). Improving Care Transitions: The Patient Perspective, *Journal of Health Communication*, 17, p. 312-324.
15. Cohen, M. (2012). Caring for B.C.'s Aging Population: Improving Health Care for All, Canadian Center for Policy Alternatives, B.C. Office.
16. Coleman, E. and Fox, P. (2004). One Patient, Many Places: Managing Health Care Transitions, Part 1: Introduction, Accountability, Information for Patients in Transition, *Annals of Long-term Care*, 12(9), p. 25-32.
17. Coleman, E. and Parry, C. (2003). The Care Transitions Intervention: A Patient-Centered Approach to Ensuring Effective Transfers Between Sites of Geriatric Care, *Home Health Care Service Quarterly*, 22(3), p. 1-17.

18. Coleman, E., Smith, J., Frank, J., Min, S.J., Parry, C., and Kramer, A. (2004). Preparing Patients and Caregivers to Participate in Care Delivered Across Settings: The Care Transitions Intervention, *Journal of American Geriatrics Society*, 52, p. 1817-1825.
19. Coleman, E. (2003). Falling Through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Complex Care Needs, *Journal of the American Geriatrics Society*, 51, p. 549-555.
20. Equity and Excellence: Liberating the NHS (July 2010). London, England.
21. Foldy, E., Goldman, L. and Ospina, S. (2008). Sensegiving and the role of cognitive shifts in the work of leadership, *The Leadership Quarterly*, 19, p. 514-529.
22. Graham, C., Ivey, S. and Neuhauser, L. (2009) From Hospital to Home: Assessing the Transitional Care Needs of Vulnerable Seniors, *The Gerontologist*, 49(1), p. 23-33.
23. Gronn, P. (2000). Distributed properties: a new architecture for leadership, *Educational Management and Administration*, 28(3), p. 317-338.
24. Home and Community Care Policy Manual, Policy and Standards, Province of B.C.
25. Health Council of Canada (2012). *Seniors in need, caregivers in distress, what are the home care priorities for seniors in Canada?* Toronto: Health Council of Canada.
26. Heifetz, R. and Laurie, D. (2001). The Work of Leadership, *Harvard Business Review*, p. 131-141.
27. Hollander, M. and Prince, M. (2008). Organizing Healthcare Delivery Systems for Persons with Ongoing Care Needs and Their Families, *Healthcare Quarterly*, 11(1), p. 44-54.
28. Hollander, M., Chappell, N., Prince, M. and Shapiro, E. (2007). Providing Care and Support for an Aging Population: Briefing Notes on Key Policy Issues, *Healthcare Quarterly*, 10(3), p. 34-45.

29. Hollander, M. and Prince, M. (2002). Analysis of Interfaces Along the Continuum of Care, Final Report: The Third Way: A Framework for Organizing Health Related Services for Individuals with Ongoing Care Needs and Their Families, Home Care and Pharmaceuticals Division, Health Policy and Communications Branch, Health Canada.
30. Howarth, M. and Haigh, C. (2007). The myth of patient centrality in integrated care: the case of back pain services, *International Journal of Integrated Care*, 7(11), p. 1-8.
31. Hughes, R. and Clancy, C. (2007). Improving the Complex Nature of Care Transitions, *Journal of Nursing Care Quality*, 22(4), p. 289-292.
32. Institute of Medicine *Crossing the Quality Chasm: A New Health System for the Twenty-first Century* (Washington: National Academy Press 2001).
33. Jeffs, L., Kitto, S., Merkley, J., Lyons, R. and Bell, C. (2012). Safety threats and opportunities to improve interfacility care transitions: insights from patients and family members, *Patient Preference and Adherence*, 6, p. 711-718.
34. Johnson, C. (2009). Health Care Transitions: A Review of Integrated, Integrative, and Integration Concepts, *Journal of Manipulative and Physiological Therapeutics*, 32(9), p. 703-713.
35. Kodner, D. (2009). All Together Now: A Conceptual Exploration of Integrated Care, *Healthcare Quarterly*, 13(Special Issue), p. 6-15.
36. Kodner, D. (2006). Whole-system approaches to health and social care partnerships for the frail elderly: an exploration of North American models and lessons, *Health and Social Care in the Community*, 14(5), 384-390.

37. Kodner, D. and Spreeuwenberg, C. (2002). Integrated care: meaning, logic, applications, and implications—a discussion paper, *International Journal of Integrated Care*, 2 (14), p. 1-6.
38. Lakomski, G. (2005). *Managing Without Leadership Towards a Theory of Organizational Functioning*, Elsevier: Oxford, U.K.
39. Leape, L., Berwick, D., Clancy, C., Gluck, P., Guest, J., Lawrence, D., Morath, J., O’Leary, D., O’Neil, P., Pinakiewicz, D., Isaac, T. (2009). Transforming healthcare: a safety imperative, *Quality and Safety in Health Care*, 18, p. 424-428.
40. Leutz, W. (2005). Reflections on Integrating Medical and Social Care: Five Laws Revisited, *Journal of Integrated Care*, p. 3-12.
41. Northern Health and Armstrong Consulting Ltd. (2012) document.
42. Northern Cancer Control Strategy;
<http://www.northerncancerstrategy.ca/AboutTheNCCS.aspx>.
43. Northern Health Integrated Care for Seniors in Prince George: Current State Analysis Report (April, 2012).
44. Northern Health, *Integrated Community Clinical Information System*, PowerPoint Presentation, May 7, 2013.
45. Northern Health, *Mobilization of Home Support Workers Project*, PowerPoint Presentation, February 2013.
46. Northern Health, *Designing Integrated Health Care for Seniors in Prince George, B.C.*, PowerPoint Presentation, October 2012.
47. Northern Health, *Strategic Plan 2009-2012*;
<http://www.northernhealth.ca/AboutUs/MissionVisionStrategicPlan.aspx>.

48. Pearce, C. and Conger, J. (2003). *Shared Leadership: Re-framing the How and Whys of Leadership*. Thousand Oaks, CA: Sage Publications, 2003.
49. Pickles, J., Hide, E. and Maher, L. (2008). Experience based design: a practical method of working with patients to redesign services, *Clinical Governance: An International Journal*, 13(1), p. 51-58.
50. Programs of All-inclusive Care for the Elderly (2005). National PACE Association;
<http://www.npaonline.org>
51. Ramsay, A., Fulop, N. and Edwards, N. (2009). The Evidence Base for Vertical Integration in Health Care, *Journal of Integrated Care*, 17(2), p. 3-12.
52. Rayner, H. (2009). The Heart of Integration, *Journal of Integrated Care*, 17(1), p. 9-14.
53. Saultz, J. and Albedaiwi, W. (2004). Interpersonal Continuity of Care and Patient Satisfaction: A Critical Review, *Annals of Family Medicine*, 2(5), p. 445-451.
54. Singh, R., Roberts, A., Singh, A., Heider, A., Norris, T., Porreca, D., and Singh, G. (2011). Improving transitions in inpatient and outpatient care using a paper or web-based journal, *Journal of Royal Society of Medicine*, 2(6), p. 1258-1266.
55. Sparbel, K. and Anderson, M. (2000). Integrated Literature Review of Continuity of Care: Part 1, Conceptual Issues, *Journal of Nursing Scholarship*, 32(1), p. 17-24.
56. Spehar, A., Campbell, R., Cherrie, C., Palacios, D., Baker, J., Bjornstad, J. (2005). Seamless Care: Safe Patient Transitions from Hospital to Home, *Advances in Patient Safety*, 1, p. 79-98.
57. Spinelli, R. (2006). The Applicability of Bass's Model of Transformational, Transactional, and Laissez-Faire Leadership in the Hospital Administrative Environment, *Hospital Topics: Research and Perspectives on Healthcare*, 84(2), p. 11-18.

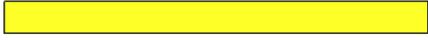
58. Suter, E., Oelke, N., Adair, C. and Armitage, G. (2009). Ten Key Principles for Successful Health Systems Integration, *Health Care Quarterly*, Special Issue, October.
59. Thaldorf, C. and Liberman, A. (2007). Integration of Health Care Organizations: Using the Power Strategies of Horizontal and Vertical Integration in Public and Private Health Systems, *The Health Care Manager*, 26(2), p. 116-127.
60. Thomas, P., Meads, G., Moustafa, A., Nazareth, I., Stange, K. and Hess, G.D. (2008). Combined horizontal and vertical integration of care: a goal of practice-based commissioning, *Quality in Primary Care*, 16, p. 425-432.
61. Transitions of Care Measures, National Transitions of Care Measures Work Group, 2008; www.ntocc.org.
62. Trebble, T., Hansi, N., Hydes, T., Smith, M. and Baker, M. (2010). Process mapping the patient journey through health care: an introduction, *British Medical Journal*, 341, p. 394-401.
63. Waibel, S., Hennaoui, D., Aller, M.B., Vargas, I., and Vazquez, M.L. (2012). What do we know about patients' perceptions of continuity of Care? A Meta-synthesis of qualitative studies, *International Journal for Quality in Health Care*, 24(1), p. 39-48.
64. Zaccaro, S. and Horn, Z. (2003). Leadership Theory and Practice: Fostering an Effective Symbiosis, *The Leadership Quarterly*, 14, p. 769-806.

Appendix A
Patient Journey—Caregiver/Wife



Legend

Monday, April 16, 2012

	Social Work
	OT/PT
	Intake Nurse
	LTC Case Manager
	Liaison Nurse
	Inpatient Nursing
	Community Services H&CC, MH&A, PH
	Patient/Caregiver Comments
	Notable Patient/ Caregiver Observations
	Event
	Physician/Specialist

Appendix B
Patient Journey—Mom/Patient

Patient Journey - Mom/Patient

4/16/2012

5/23/2012 - 5/30/2012
1 week Period

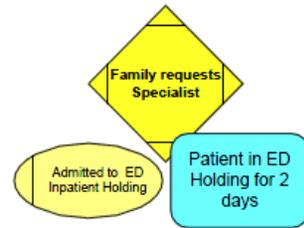
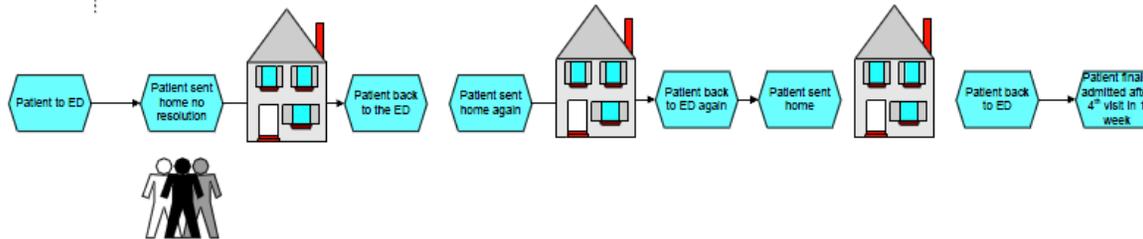
Husband felt that 1st 3 times that his wife was sent home was due to the ED being short staffed



Patient and family not ever told patient was admitted so they were not sure what was happening



Patient and Family

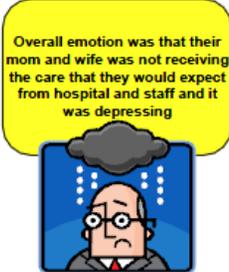


Patient and Family told to wait in waiting room. The waiting room was very uncomfortable



Patient and family had a range of emotions during their stay in ED and Rehab

Upset
Depressed
Hurt
Angry
Stressed
Frustrated



Patient was transferred to Rehab



Again the Family did not understand why Mom was in Rehab

Patient In Rehab from April to December (8 months)



Family was not given explanation as to why Mom was in Rehab. No confirmed diagnosis

Family thought that there were a lack of beds in hospital and Mom should have been on a medical ward

Rehab Department

Families experience in Rehab was a "nightmare"!

Family made dinners and food and brought it into their mom



Patient was in constant pain but was continually asked by staff to go to dining room for dinner.

Patient was unable to walk but was told by Rehab staff "we have rules here and you need to get up"



Non verbal communication from staff was very intimidating

Family requests Specialist again!

Family felt that Mom was treated like a "non compliant" patient and felt she would have been better treated in "jail"



Family was very hurt by staff treatment of their wife and mother

Family felt mom should be on a medical floor

Family observed other patients and families were also unhappy

Questions about Meds not answered



Various nurses rude and inappropriate calling patient "honey" in a condescending tone. Even though Mom in pain staff insisted she "follow the rules"

Patient and Family concerns ignored



Nurses heard complaining about patient

Family bugged that the nurses were complaining

Patient moved into the hall to sleep because she was ringing the bell too often

Patient felt humiliated by nursing staff

Patient asked to sign a contract that she was only allowed to "pee" every 4 hrs

Patient diapered as she was felt to be too much work!



Family searched the internet for help

Husband and family had multiple meetings with Family Physician to request specialist

Husband and family requested additional Tests (T-Scan)

Doc rude and arrogant. Asked family to leave office

Family requested Specialist and GP refused to refer

Obtained new GP who referred to Specialist



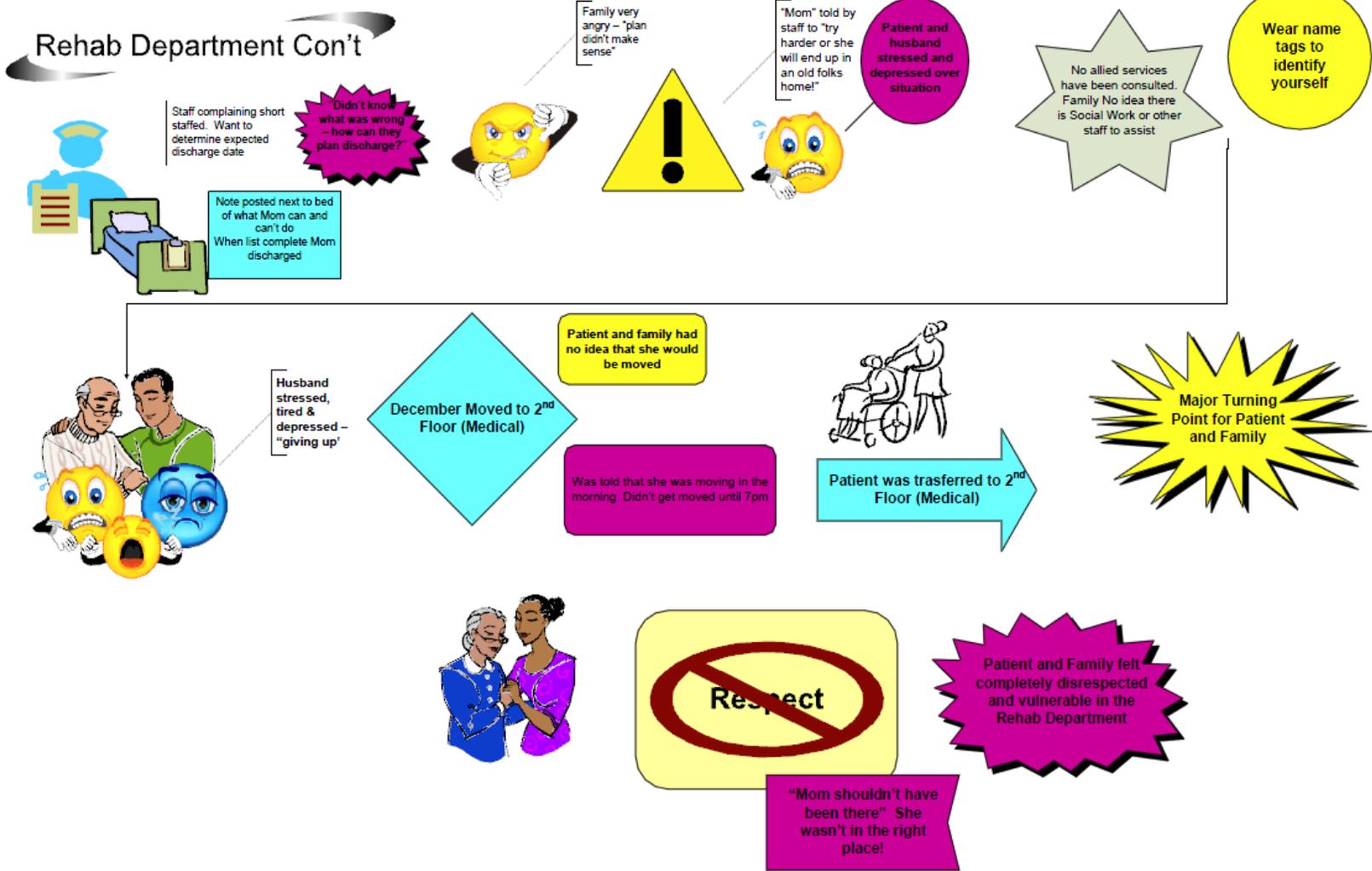
Family was told had Specialist been consulted Mom would have not been so bad off

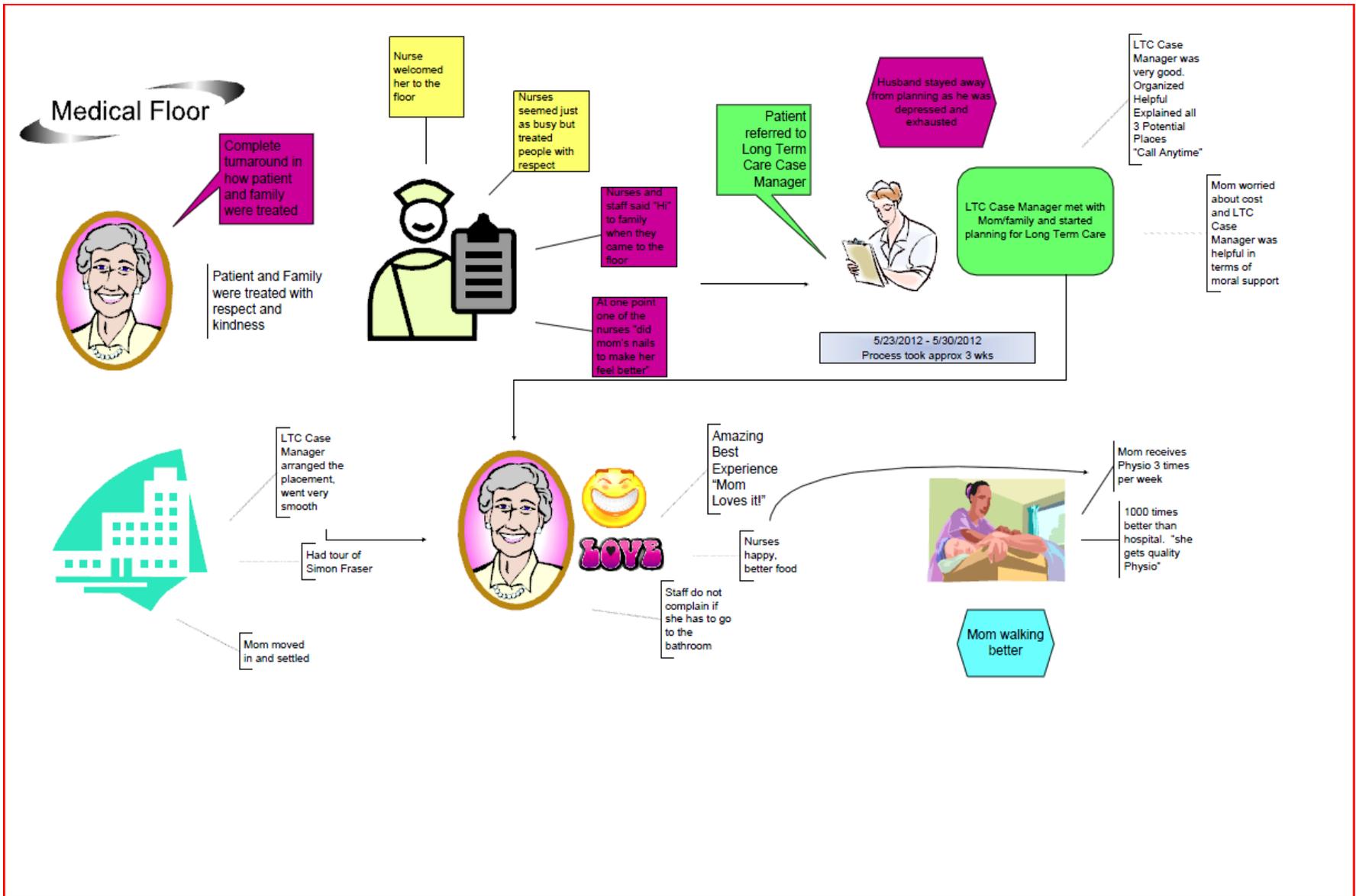
Patient received a confirmed Diagnosis



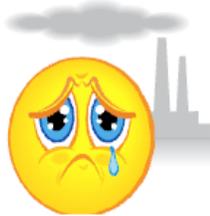
Overall Health Improving

Rehab Department Con't





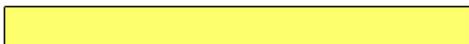
Overall Experience and Message



Overall experience was a "nightmare" for patient and family "It was a horrible experience"

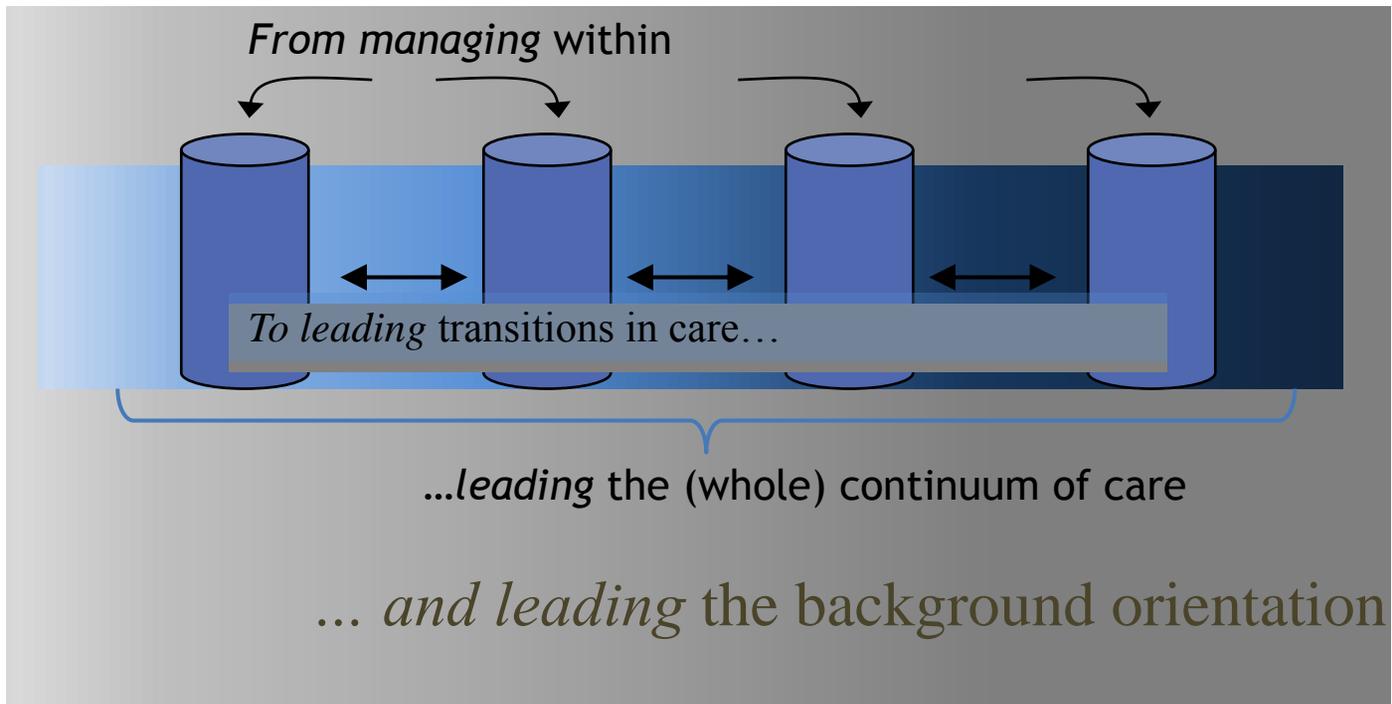
Treat people how you want to be treated. One day it will be you or one of your family members.

Legend

	Social Work
	OT/PT
	Intake Nurse
	LTC Case Manager
	Liaison Nurse
	Inpatient Nursing
	Community Services H&CC, MH&A, PH
	Patient/Caregiver Comments
	Notable Patient/ Caregiver Observations
	Event
	Physician/Specialist

Appendix C

From Managing Within to Leading Transitions in Care to Leading the Whole Continuum of Care



Appendix D

Whole versus Parts: A Metaphor for Designing Seniors Care

Whole vs. parts: A metaphor for designing Seniors Care

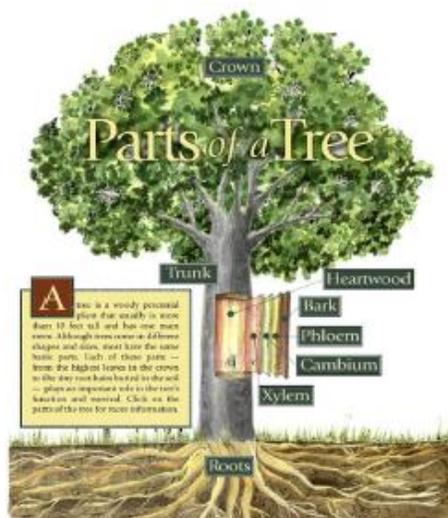
Parts of a tree

The Canadian Forestry Association identifies the following parts of tree on its website:

- Leaves and needles
- Buds
- Cones and flowers
- Branches and twigs
- Trunk or stem
- Roots

The North Carolina Forestry Association identifies some of the same and some slightly different parts:

- Crown
- Trunk
- Heartwood
- Bark
- Phloem
- Cambrium
- Xylem
- Roots



Seniors Design did not start by putting a collection of branches, twigs, bark and roots on the table and then trying to determine how to attach them to each other to produce a tree. The best we could do with that approach would be, like an elementary school project, to produce a representation of a tree. You could look at it and see the major elements but there's no chance it would come alive and grow. It wouldn't be a real living tree although if we completed our project well, it would look very tree-like.

Growing a tree

So if you don't get a tree by putting together a collection of parts; how do you get a tree? You plant a tree, seedling, clipping or seed from which to grow a tree or a larger tree.

The first step is to determine what you want the tree to provide: shade, color in the fall, deep roots to hold the soil in place or other things of importance. This will help you determine the type of tree that will meet your needs.

We cannot rip the current tree out by its roots and replace it with another tree. We need to grow a tree. Here's what wikiHow says about planting a tree:

1. Select the right time of year for planting the tree.
2. Check to see if there are any local requirements concerning digging deep holes.
3. Choose a suitable tree for the region, climate, and space.
4. Prepare the hole.
5. Prepare the tree for planting.
6. Place the tree into the hole gently.
7. Use some compost or composted manure if needed.
8. Resist the temptation to use a commercial fertilizer; it tends to overboost the tree and make it less likely to do well over the long term.
9. Give fruit and nut trees extra attention.
10. Water the newly planted tree.
11. Mulch, mulch, mulch!
12. Water it again.
13. Stake the tree if necessary, for about the first year.
14. Keep watering your tree for the first few years as it gets established.
15. Enjoy the tree as it grows over the years with you, your family and friends.

The first 14 steps are all about establishing the conditions (conditioning) in which a real live tree can start from something small, grow into something larger and flourish. And it didn't start with parts. It started with careful selection and a lot of hard work over time.

The 15th step is about appreciation of what has been accomplished, what it provides and listening for what's next.

You have determined what you want the tree to provide and have described the type of tree that will be. Now we need to prepare the organization; establish the conditions in which that tree can grow. Metaphorically it will have more to do with compost, water, mulch and extra attention. Not much to do with a hammer, nails, screws, wire and duct tape.

Primarily it will be about leading conversations that establish a new culture of care – a new orientation to care. While there will be action required; action plans and to-do lists will not be the cause of the new design coming to life.