Leading Integrated Health and Social Care Systems: Perspectives from Research and Practice

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Abstract

As the research evidence on integrated care has evolved over the past two decades, so too has the critical role leaders have for the implementation, effectiveness and sustainability of integrated care. This paper explores what it means to be an effective leader of integrated care initiatives by drawing from the experiences of a leadership team in implementing an award-winning integrated care program in Toronto, Canada. Lessons learned are described and assessed against existing theory and research to identify which skills and behaviours facilitate effective leadership of integrated care initiatives.

Introduction

The rising number of individuals with multiple complex and chronic health conditions, combined with significant economic pressures, has propelled healthcare systems around the globe into rapid transformation (Wodchis et al. 2015). Healthcare providers recognize that the traditional silos for delivery of care are not capable of meeting the significant and varied needs of current and emerging patient populations. Integrating services across different organizations and providers and ensuring a continuum of care is critical to support patients who routinely access care from multiple sources. For leaders of healthcare organizations, this requires the skills to think and act with a "system" versus "organizational" perspective and to shift focus from what works for providers and organizations to what patients and families say is most important to them. Other skills and competencies that are required of healthcare leaders are similarly shifting.

Bringing multiple clinical and social service providers together to integrate care and create "one team" for complex patients and their families involves modifying how diverse organizations and professionals work and how they interact. Achieving such transformation across the healthcare system requires a multilevel strategy targeting policy, funding, organizational, provider and patient and family/caregiver factors (Suter et al. 2009). As the research evidence on integrated care has accumulated over the past two decades, so too has recognition of the influence leaders have on the implementation, effectiveness and sustainability of integrated care delivery (Edgren and Barnard 2012; Evans et al. 2015; Fillingham and Weir 2014; Suter et al. 2009).

Leading across complex interdependent sectors and settings of care is a new and challenging role for healthcare leaders who are already tasked with directing the internal affairs and performance of their organizations. This paper explores what it means to be an effective leader of integrated care initiatives by drawing from the experiences of the leadership team at the Toronto Central Community Care Access Centre (TC-CCAC) whose integration work spans the full continuum of care and has received numerous leadership awards and recognition. Lessons learned are described and assessed against existing theory and research to identify which skills and behaviours facilitate effective leadership of integrated care initiatives.

Leading Integrated Care: Competencies and Theories

Numerous healthcare leadership competency frameworks exist which identify the skills and behaviours leaders need to achieve superior performance in the management of healthcare organizations. Six leadership competency frameworks were chosen as a lens by which to explore the competencies required to lead integration. These frameworks are research-informed, used widely in practice and hail from diverse jurisdictions including the United States, Canada and the UK (Calhoun et al. 2008; CCHL 2013; Dickson et al. 2007; NHS Leadership Academy 2013; Provost et al. 2006; Stefl and Botempo 2008). A competency framework specifically for leading integrated care was recently developed, but the methods used to identify these competencies were not specified (Fillingham and Weir 2014); therefore, the theoretical and empirical base for the framework is unclear. Table 1 outlines leadership competencies across these seven frameworks, which overlap considerably with common themes including the development of a shared vision and the management of relationships, performance and change.

The most commonly used theory for examining the role of leadership in integrating care is Complex-Adaptive Systems (CASs) Theory (Edgren and Barnard 2012; Fillingham and Weir 2014; Tsasis et al. 2012). Several scholars have described healthcare in general (Plsek and Greenhalgh 2001) and integrated care delivery in particular (Tsasis et al. 2012) as CASs. CASs are capable of self-organizing without external control through relationships and interactions among diverse agents. A CAS lens suggests that a facilitative, distributed model of leadership works best in which everyone shares responsibility for leading integrated care efforts, including those without formal leadership positions such as front-line staff members (Edgren and Barnard 2012; Fillingham and Weir 2014). Leaders can positively influence integrated care delivery by demonstrating strong, consistent support for the initiative, empowering front-line staff to determine the required changes and removing barriers (Suter et al. 2009; Tsasis et al. 2012; Wheatley 2006).

In CASs, the future is unpredictable, so sensemaking and sensegiving are more important leadership behaviours than traditional "command-and-control" approaches (McDaniel and Driebe 2001). Sensemaking has to do with the way individuals understand and interpret a strategic change such as service integration (Weick 1995). Sensegiving is concerned with how leaders communicate their thoughts about the change to others and gain their support (Gioia and Chittipeddi 1991). The idea that we need to "make sense" of the integrated care process highlights the complexity of bringing together multiple diverse providers to improve care for shared patients. Often, there are differences in how "integrated care" is defined and understood, and varying perceptions of respective roles and desired outcomes (Evans et al. 2012; Pate et al. 2010). Leaders play a role in framing the integrated care process in ways that surface these differences and facilitate negotiation and understanding.

Integrated Care Interventions led by the TC-CCAC

The Toronto Central Community Care Access Centre (TC-CCAC) has a mandate to enhance access and care coordination for complex clients. In partnership with clients and primary care providers, TC-CCAC develops comprehensive care plans; delivers home care services that support people to live at home; identifies and connects clients with community and social programs and services; and supports people to transition through the healthcare system including hospital to home and to long-term care.

The TC-CCAC has earned several local and national awards for developing and leading innovative integrated care models and practices, including:

- the 2014 Ontario Minister's Medal (top honour) for Excellence in Health Quality and Safety for its integrated client care program for palliative care;
- the 2013 Ontario Minister's Medal Honour Roll for Excellence in Health Quality and Safety for its integrated client care program for older adults with complex care needs;
- a "High Impact Practice" designation from the Canadian Home Care Association; and
- a "Leading Practice" designation from Accreditation Canada.

The TC-CCAC's most prominent contribution to integrated care is the Integrated Care for Complex Populations (ICCP) program, a multi-year strategy for integrating care for populations with complex needs. Key features of the program include: (a) a single point of access, (b) an interdisciplinary, inter-organizational team of providers, (c) partnerships with primary care, hospitals, specialists, community support service and Emergency Medical Services, (d) case management/care coordination across the continuum of care, (e) individualized coordinated care plans for patients and families driven by what is most important to them, (f) medication management and (g) patient and family/caregiver education and support (Goldhar et al. 2015). Each integrated care team has a CCAC care coordinator who ensures that inter-organizational and interdisciplinary team members work together for joint assessments, joint care planning and joint home visits and/or virtual case conferences. Since its inception in 2011, ICCP for Older Adults, Palliative Care and Children with complex medical needs has supported thousands of clients and their families.

TC-CCAC Lessons Learned for Leading Integrated Care Initiatives

Through a series of open discussions among the TC-CCAC leadership team and an external researcher (See Appendix), three key lessons emerged for leading integrated care.

TABLE 1.
Seven International Healthcare Leadership Competency Frameworks

Healthcare Leadership Framework	Leadership Competencies, Behaviours and Skills
Framework for Leadership of Improvement (Provost et al. 2006)	**Set direction: mission, vision and strategy** (communicate the direction to all stakeholders) **Establish the foundation** (choose, develop and align a leadership team, build relationships and establish improvement capability) **Build will for change** (plan for improvement, set aims, allocate resources, measure performance and provide encouragement) **Generate ideas** (listen to patients and other stakeholders, benchmark, scan widely for external ideas, invest in research and development and understand the organization as a system) **Execute change** (test, adapt and implement new ideas, spread good ideas, communicate results and sustain improvement)
Pan-Canadian Health Leadership Capability Framework (Dickson et al. 2007)	**Champion caring** (inspire and encourage commitment to health, show respect for all, act with compassion and exhibit fairness) **Cultivate self and others** (demonstrate self-awareness and self-management, exhibit character, enable others to grow and create engaging environments where people have meaningful opportunities to contribute) **Connect with others** (communicate effectively with diverse stakeholders, build teams, develop networks and partnership and navigate socio-political environments) **Create results** (develop a shared vision, hold self and others accountable, use quality improvement and evidence in decision-making and manage resources) **Change systems** (build understanding of the complexity of the health system, mobilize knowledge and lead changes)
National Center for Healthcare Leadership Competency Model (Calhoun et al. 2008)	**People** (human resources management, relationship building, interpersonal understanding, professionalism, team leadership and talent development) **Transformation** (innovative thinking, strategic orientation, information seeking, analytical thinking and financial acumen) **Execution** (communication and collaboration skills, change leadership, accountability, project management and performance measurement)
The Healthcare Leadership Alliance Model (Stefl and Botempo 2008)	**Communication and relationship management** (communicate clearly with internal and external customers, establish and maintain relationships and facilitate constructive interactions) **Leadership** (inspire excellence, create a shared vision and manage change) **Professionalism** (align conduct with ethical and professional standards and commitment to lifelong learning and improvement) **Business knowledge and skills** (systems thinking, financial management, human resource management, governance, strategic planning and marketing, information management, risk management and quality improvement) **Knowledge of the healthcare environment** (understand the healthcare system and environment in which managers and providers function)
LEADS in a Caring Environment Framework (CCHL 2013)	**Systems transformation** (systems thinking, change management and continuous improvement) **Develop coalitions** (build diverse partnerships and networks) **Achieve results** (set direction, make evidence-based decisions and evaluate outcomes) **Lead self** (self-awareness and personal development) **Engage others** (communicate effectively, build teams and foster the development of others)
NHS Healthcare Leadership Model (NHS Leadership Academy 2013)	**Inspire shared purpose** (create and role model shared purpose and values for diverse individuals doing different work, question the way things are done and take personal risks to stand up for the shared purpose) **Lead with care** (understand underlying emotions of self and staff, care for staff members' emotional well-being and provide opportunities for mutual support) **Evaluate information** (seek out varied information, data and feedback, measure and analyze performance over time, use information to generate ideas and plans for change and make evidence-based decisions) **Connect services** (recognize how one's own area of work relates to other parts of the system, understand the culture and politics across the organization and build strategic relationships to make links across the broader system) **Share the vision** (create a clear and compelling picture of what everyone is working towards and use ongoing communication strategies) **Engage the team** (promote teamwork, value individuals' contributions and encourage individuals to identify problems and solve them) **Hold to account** (set clear expectations for self and others, provide performance feedback and support continuous improvement) **Develop capability** (provide learning and development opportunities to staff, provide mentoring, identify capability gaps and take steps to rectify them) **Influence for results** (adapt communication to connect with diverse groups, develop collaborative agendas and consensus and build sustainable commitments/agreements)
Knowledge and Skills Framework for Leadership Across Integrated Systems (Fillingham and Weir 2014)	**Technical know-how** (service design, governance arrangements, innovative contracting and financial mechanisms and technological savvy) **Improvement know-how** (systems thinking, improvement science and large-scale change) **Personal effectiveness** (interpersonal skills and behaviours, coaching ability and visionary and participative style)

Lesson 1: *Change the Conversation*

Traditionally, partnerships aimed at integrating care are characterized initially by a focus on clarifying respective roles in the joint initiative and defining performance metrics for evaluating success (Minkman et al. 2009). However, Wheatley (2006) notes, changing from a "task-focused" delivery model to a "communication-based" delivery model has greater likelihood of success because it focuses on building strong relationships versus focusing on tasks, functions, span of control and hierarchies – the latter examples being more traditional ways to deliver healthcare. The TC-CCAC initiated the change process by talking to patients and families to understand what is most important to them. Then the TC-CCAC re-framed its early conversations with existing and potential partners by focusing on how patients experience the healthcare system and by asking questions such as, "How can we make it better?" and "What do we *really* want to achieve together?" Posing these questions helped direct attention away from the mandates of each organization, and re-focus attention on the possibilities of what might be accomplished through collaboration for the organizations involved, and for patients and the healthcare system at large. These conversations generated multiple improvement opportunities. For example, the TC-CCAC used patient feedback to create One client, One team™ (trade-mark of TC-CCAC), which brings together providers from different organizations as one team. Other improvement opportunities that emerged include providing medication reconciliation during transitions from acute care to home to prevent hospital readmissions, creating coordinated care plans that span multiple providers, and developing a means to transfer critical patient information when paramedics respond to emergency calls.

One of the goals of changing the conversation among partnering organizations in this way is to break down boundaries between professionals and organizations, and create a sense of shared purpose and identity. Building a shared identity can be difficult for individuals who have been socialized into their professional roles and for organizations that have built a strong brand in the community (Pate et al. 2010). In order to change behaviours, leaders need to identify the values and agreements that will support the new behaviours and act congruently with desired values. The leader's role is to ensure there is strong and evolving clarity about *why*, not what, how or when (Wheatley 2006).

The TC-CCAC realized that its efforts to change the conversation and foster a shared identity among partners were successful through two separate incidents. The first was at an event where several CCAC staff members identified themselves as members of an external primary care team in which they had been embedded. In other words, employees of different organizations perceived themselves as having a shared identity. The second example occurred when partnering organizations took ownership and shared credit for an initiative that started with TC-CCAC and spread. In both cases, the TC-CCAC interpreted these incidents as indicators of success that boundaries were being blurred, best practices were being shared and adopted and that organizations were working collaboratively not competitively.

Lesson 2: *Self-Reflect and Adapt*

Leading integrated care initiatives requires proficiency in relationship-building. Traditional healthcare leadership competencies in technical areas, such as financial management and strategic planning, are inadequate. Effective relationship-building involves creating meaningful connections, trust and shared meaning among diverse individuals and groups.

The TC-CCAC's approach to relationship-building involved constant reflection on the context and each partner: What is working? What is not working? What motivates each partner? What do they want from the relationship? Ongoing reflection on these questions enabled the TC-CCAC leadership team to tailor their tactics to the evolving needs and expectations of each partner.

Management tactics may also be tailored based on the implementation stage of an integrated care initiative and the maturity of the relationships involved. In the early stages, there is a need to develop trust and respect. Delivering on early commitments and creating opportunities for interaction are thus priorities. In later stages of the partnership, the focus expands to more difficult conversations about roles, accountability and funding. Without first building a foundation for understanding each organization's perspective, it is unlikely that organizations will easily move to decision-making that impacts "turf," such as conversations about respective responsibilities and resource commitments or "ownership" of programs and services.

Lesson 3: *Allow for Evolution*

Experts emphasize the importance of adapting integrated care models and interventions to the local context to enhance the probability of success (Bardsley et al. 2013). The TC-CCAC approach to implementing the ICCP allowed for local adaptation and learning over time through trial and error. Rather than calling ICCP a "pilot project," the TC-CCAC deliberately framed the initiative as a "multi-year strategy." This choice of wording was specifically designed to demonstrate long-term commitment.

There was also no *a priori* script for how the integrated care model would look or how change would be implemented. Instead, the TC-CCAC utilized an approach of rapid testing, which allowed the ICCP to be implemented and refined over time based on qualitative feedback from staff members, external providers, patients and caregivers. For example, rather than strictly defining roles and responsibilities upfront, the TC-CCAC gave their staff members

permission to make key decisions regarding how best to deliver services at the point of care. Staff members were encouraged to share and discuss their experiences at regular meetings, and this information was used collaboratively and iteratively to inform the development of formal policies and procedures.

The team noted that, as their internal organizational culture evolved with the implementation of ICCP, this created ripple effects which influenced others in the immediate context.

Discussion

Three overarching lessons emerged from the TC-CCAC leadership team's experience implementing ICCP: change the conversation, self-reflect and adapt and allow for evolution. These lessons align with the principles of CAS and sensemaking theories, which emphasize relationships and interactions among stakeholders, attention to context, continuous adaptation through learning and distributed leadership. The key lessons learned by the TC-CCAC leadership team also overlap with the content of existing healthcare leadership competency frameworks (Table 1). However, these frameworks outline a broad range of leadership competencies. The frameworks do not specify in adequate detail which leadership skills and behaviours are most important for managing effectively the challenges inherent in integrating care.

In Table 2, we present a leadership competency framework specific to integrating care. The framework highlights key skills and behaviours for those leading initiatives aimed at integrating care for populations with complex care needs. These include: (1) framing and re-framing issues, (2) taking the perspective of others, (3) focusing on patients and caregivers, (4) systems thinking, (5) sharing power and (6) reflective learning.

First, leaders play a key role in framing how stakeholders view and interpret the integrated care initiative. Careful consideration must thus be paid to messaging both in terms of the language leaders use and the actions leaders take. Leaders skilled in framing tailor their message to the audience, incorporate multiple stakeholder perspectives and focus attention on finding common ground.

Second, leaders of integrated care initiatives must understand what motivates current and potential partners and how these underlying motivations shape their decisions and actions. By taking the perspective of others, leaders can frame issues and conversations in ways that recognize the respective needs and contributions of various partners.

Third, effective leaders gather information on the needs and preferences of patients and their caregivers to inform the design of integrated care initiatives. They also view care processes through the eyes of patients and families to understand which components add value and which do not. Focusing on patients and caregivers, rather than organizations and providers, is a useful method for unifying the diverse interests of partners.

Fourth, a micro-level focus on patients and caregivers must be balanced by a macro-level view of the healthcare system as a whole. In systems as complex and dynamic as healthcare, well-intentioned changes to structures or processes in one part of the system often have unintended consequences in other parts of the system (McDaniel and Driebe 2001). In designing and implementing integrated care initiatives, leaders must consider simultaneously the experience of patients and their caregivers as well as the performance of the healthcare system.

Fifth, effective leadership of integrated care is both an individual and a collective phenomenon. Success is predicated on leaders sharing authority over decision-making and work so that staff can shape and take ownership of the change process.

Finally, applying a learning lens to how integrated care initiatives are framed and implemented empowers staff to take risks and facilitates ongoing improvement. A learning lens emphasizes tactics such as small-scale testing, performance measurement, tolerance for failure and ongoing reflection.

TABLE 2.
Key Leadership Skills for Integrating Care for Populations with Complex Care Needs

Leadership Behaviour	Description	Desired Outcome
Framing and Re-Framing Issues	Using communication to influence how others see an issue and focusing their attention on particular aspects of the issue to bring clarity and agreement to complex or ambiguous situations	Shared purpose, shared identity and consensus-building among partners
Taking the Perspective of Others	Seeking an accurate understanding of the thoughts, feelings, motivations and intentions of current and potential partners, and using this information to build a "safe space" for partners to be open and collaborative	Stronger, more trusting relationships among partners
Focusing on Patients and Caregivers (Micro-Level View)	Ensuring care delivery is responsive to what is most important to patients and their caregivers, not providers and organizations	Patients and caregivers experience providers as a single team working in partnership with them
Systems Thinking (Macro-Level View)	Analyzing situations and problems by focusing on the linkages and interactions between different components of the healthcare system, rather than focusing on components or events in isolation	More synergistic solutions for fostering an integrated healthcare system
Sharing Power	Enabling those around you to think and behave in autonomous ways, and to control and take credit for work and decision-making	More engaged workforce that takes ownership of integrated care delivery
Reflective Learning	Thinking about and analyzing what one has done (or is doing) to identify factors affecting success, and embracing failure as an opportunity to learn and improve	Continuous improvement towards the vision of integrated care

Conclusion

Integrating care involves modifying how diverse organizations and professionals work and how they interact through changes to high-level policies, funding arrangements or organizational and provider configurations. These fundamental changes to how care is structured and delivered demand "system leaders" with leadership competencies that support effective and sustainable relationship development among traditionally disparate components of the healthcare system.

Drawing from the practical experiences of the TC-CCAC leadership team, as well as prominent scholarly theories, the lessons presented suggest that, in addition to developing the leadership capacity of individuals, we must also develop collective leadership capacity across the healthcare system. HQ

References

Bardsley, M., A. Steventon, J. Smith and J. Dixon.2013. *Evaluating Integrated and Community Based Care: How Do We Know What Works?* London: Nuffield Trust.

Calhoun, J., L. Dollett, M. Sinioris, J. Wainio, P. Butler, J. Griffith et al. 2008. "Development of An Interprofessional Competency Model for Healthcare Leadership." *Journal of Healthcare Management* 53(6): 375.

Canadian College of Health Leaders (CCHL). 2013. "LEADS in a Caring Environment Framework." Retrieved January 15, 2016. <http://www.leadersforlife.ca/site/framework?nav=02>.

Dickson, G., D. Briscoe, S. Fenwick, Z. MacLeod and L. Romilly. 2007. *The Pan-Canadian Health Leadership Capability Framework Project*. Ottawa: Canadian Health Services Research Foundation.

Edgren, L. and K. Barnard. 2012. "Complex Adaptive Systems for Management of Integrated Care." *Leadership in Health Services* 25(1): 39–51.

Evans, J.M. and G.R. Baker. 2012. "Shared Mental Models of Integrated Care: Aligning Multiple Stakeholder Perspectives." *Journal of Health Organization and Management*. 26(6): 713-36.

Evans, J.M., A. Grudniewicz, W.P. Wodchis and G.R. Baker. 2015. "Leading the Implementation of Health Links in Ontario." *Healthcare Papers* 14(2): 21–25.

Fillingham, D. and B. Weir. 2014. *System Leadership: Lessons and Learning from AQuA's Integrated Care Discovery Communities*. London: The King's Fund.

Gioia, D. and K. Chittipeddi. 1991. "Sensemaking and Sensegiving in Strategic Change Initiation." *Strategic Management Journal* 12(6): 433–48.

Goldhar, J., S. Daub, I. Dhalla, P. Ellison, D. Ellison and S. Sinha. 2015. "Integrated Client Care for Frail Older Adults in the Community: Preliminary Report on a System-Wide Approach." *Healthcare Quarterly* 17(3): 61.

Provost, L., D. Miller and J. Reinertsen. 2006. *A Framework for Leadership of Improvement*. Cambridge, MA: Institute for Healthcare Improvement.

McDaniel, R. Jr. and D. Driebe. 2001. "Complexity Science and Health Care Management." In J.D. Blair, M.D. Fottler and G.T. Savage, eds., *Advances in Health Care Management* (pp. 1-36). Stamford: JAI Press.

Minkman, M., K. Ahaus and R. Huijsman. 2009b. "A Four Phase Development Model for Integrated Care Services in the Netherlands." *BMC Health Services Research* 9(42). doi:10.1186/1472-6963-9-42.

NHS Leadership Academy. 2013. *Healthcare Leadership Model: The Nine Dimensions of Leadership Behaviour*. Leeds: NHS Leadership Academy.

Pate, J., M. Fischbacher and J. Mackinnon. 2010. "Health Improvement: Countervailing Pillars of Partnership and Profession." *Journal of Health Organization and Management* 24(2): 200–17.

Plsek, P. and T. Greenhalgh. 2001. "The Challenge of Complexity in Health Care." *British Medical Journal* 323: 625–28.

Stefl, M. and Botempo A. 2008. "Common Competencies for All Healthcare Managers: The Healthcare Leadership Alliance Model." *Journal of Healthcare Management* 53(6): 360.

Suter, E., N. Oelke, C. Adair and G. Armitage. 2009. "Ten Key Principles for Successful Health Systems Integration." *Healthcare Quarterly* 13(Special): 16–23.

Tsasis, P., J. Evans and S. Owen. 2012. "Reframing the Challenges to Integrated Care: A Complex Adaptive Systems Perspective." *International Journal of Integrated Care* 12. Retrieved January 15, 2016. <www.ijic.org.URN:NBN:NL:UI:10-1-113786>.

Weick, K. 1995. *Sensemaking in Organizations* (Foundations for Organizational Science). Thousand Oaks, CA: Sage.

Wheatley, M. 2006. *Leadership and the New Science*. San Francisco, CA: Berrett-Koehler Publishers.

Wodchis, W.P., A. Dixon, G. Anderson and N. Goodwin. 2015. "Integrating Care for Older People with Complex Needs: Key Insights and Lessons from a Seven-Country Cross-Case Analysis." *International Journal of Integrated Care* 15. Retrieved January 15, 2016. <www.ijic.org/index.php/ijic/article/view/2249/3029>

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Appendix: Semi-Structured Interview Guide

1. What principles or values underpin your approach to leading?
   1a. What leadership competencies underpin your approach to leading?
2. What kind of leadership is needed to increase the probability of success in integrated care initiatives? How do you know?
   2a. What is it about this leadership style/approach that makes it difficult to achieve or enact?
3. What kind of leadership does not work when it comes to integrating care? How do you know?
4. What are the enablers and barriers to effectively leading integrated care?
   4a. What are the key success factors?
5. Should the leadership approach change over the lifespan of the integrated care initiative?
   5a. Is what is needed different at the planning stage versus the implementation stage versus the spread stage?
6. Is the kind of leadership required to lead the process of integrating care different than it would be for other major change initiatives?
7. What are some lessons learned from your experience leading integrated care initiatives?