



Health Networks Theory of Change

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Fiona Fick | SHA Research Unit | fiona.fick@saskhealthauthority.ca

Dr. Brandy Winqvist | Academics & Learning | brandy.winqvist@saskhealthauthority.ca

HEALTH NETWORKS THEORY OF CHANGE

Overview

A theory of change (ToC) provides a plausible explanation as to how and why an intervention works (or does not work) by explicating hypothesized causal pathways between HNs and their desired outcomes and provides a foundation for analyzing the contribution of HNs to those outcomes. A ToC is a tool that will continually evolve through feedback from stakeholders and unfolding of outcomes, which allows for theory adjustment and changes to the initiative.

Realist methodology was utilized in creating this ToC. Realist explanation assumes that successful *outcomes* occur when the initiative activates certain *mechanisms* in certain *contexts*. Context includes anything outside the direct purview of the intervention, and is important in understanding the process of change as it can affect decisions that are made and responses to those decisions. Mechanisms explain how and why the causal link is expected to operate, in other words, how event X is connected to outcome Y. The goal was to understand the underlying mechanisms which produce change, the contextual factors necessary to activate these mechanisms, and how the combination of context and mechanisms produces outcomes.

There are four levels of the organization of a health system:

1. The *macro* level: policy and governance issues. Macro-level integration aims to integrate care initiatives across a range of services and to deliver this to the population.
2. The *meso* level: organization and coordination of regional health, community, social, and infrastructure services. Services deliver integrated care for population groups with similar conditions, for example, mental health needs. This can occur through organizational integration where services are merged through structural change.
3. The *micro* level: provision of integrated patient-centred care in the local community.
4. The *nano* level: issues of personal health, functional independence, and the self-management of one's well-being and diseases.

The theory of change outlined below covers the macro, meso, and micro levels. Creating a theory of change of nano level issues would involve patient feedback, which was not possible to obtain at this time. Two main ToCs were created: the first outlined successful HNs and the second explained why HNs may not be successful. As well, several levels of ToC were created: an overarching ToC as well as the macro, meso, and micro levels of HNs.

Multiple sources of data were used to create the initial theory: 1) a review of the internal HN literature and attendance at various HN related meetings, 2) interviews with relevant stakeholders, and 3) peer-reviewed literature on integrated care.

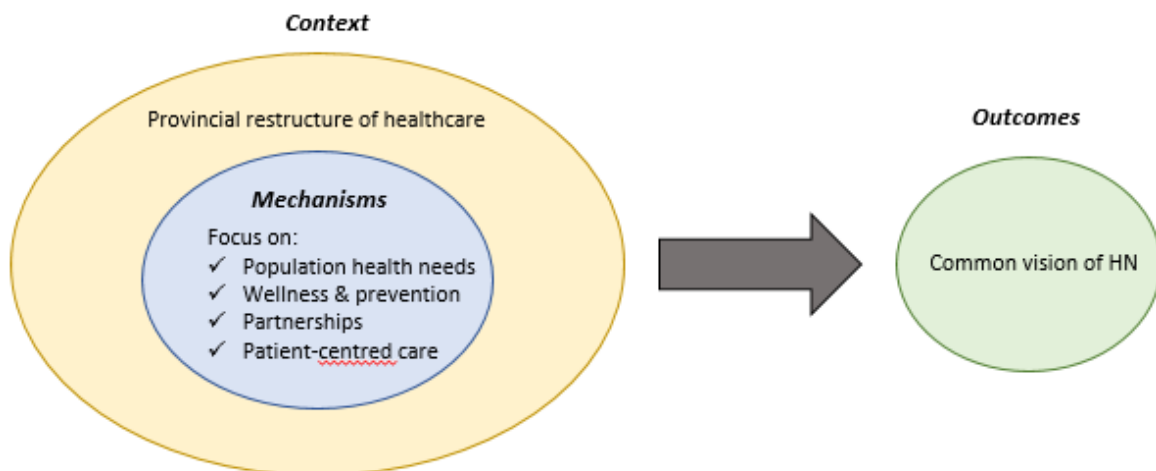
Theory of Change: Success

Macro level

Context: There is a provincial drive to restructure provision of healthcare through the integration of services. This is thought to potentially provide better care and reduce costs.

Mechanisms: Population health needs are the drivers of care provision. There is a desire to move to a preventive model of care that focuses on wellness and prevention. Partnerships with communities and community-based organizations are seen as necessary. Patient-centred care means that health care services revolve around the patient.

Outcomes: There is a common vision where people are aware of Health Networks, the expected benefits, and the rationale for them.



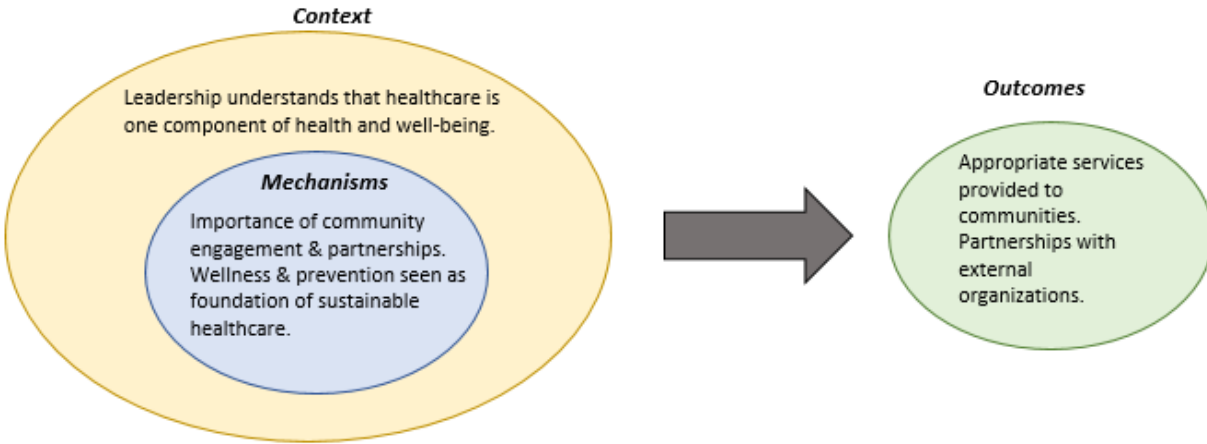
Meso level (Community)

Context: Leadership understands that healthcare is only one component of health and well-being.

Mechanisms: Leadership understands the importance of partnerships and engagement with community resources to address SDoH. Wellness and prevention are understood to be a foundational element of high quality, sustainable healthcare.

Leadership engages with communities and understands the culture, history, and needs of the communities. The community engages with the SHA to find ways to meet citizens' needs.

Outcomes: Partnerships are established with external organizations. Appropriate services are provided to each community.

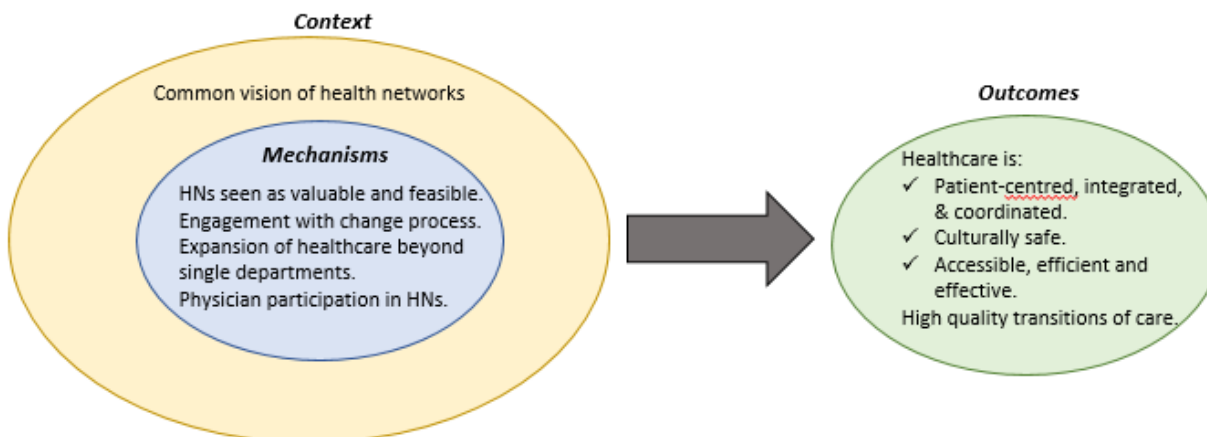


Meso level (Health Networks)

Context: There is a common vision where people (SHA staff, physicians, and communities) are aware of Health Networks and the rationale for them.

Mechanisms: SHA leadership and healthcare providers see the need for change and are engaged with the change process. Health Networks are seen as valuable and feasible. Physicians are willing to participate in network model. Views of healthcare expand beyond single departments.

Outcomes: HNs offer integrated, coordinated team-based healthcare that is culturally safe, efficient, and effective. Services are wrapped around the patient, with accessible care provided as close to home as possible and seamless, high-quality transitions of care. Health Networks are responsive to the changing needs of patients, based on demographics and usage patterns, and they allow for strong relationships between patients, families, and providers.

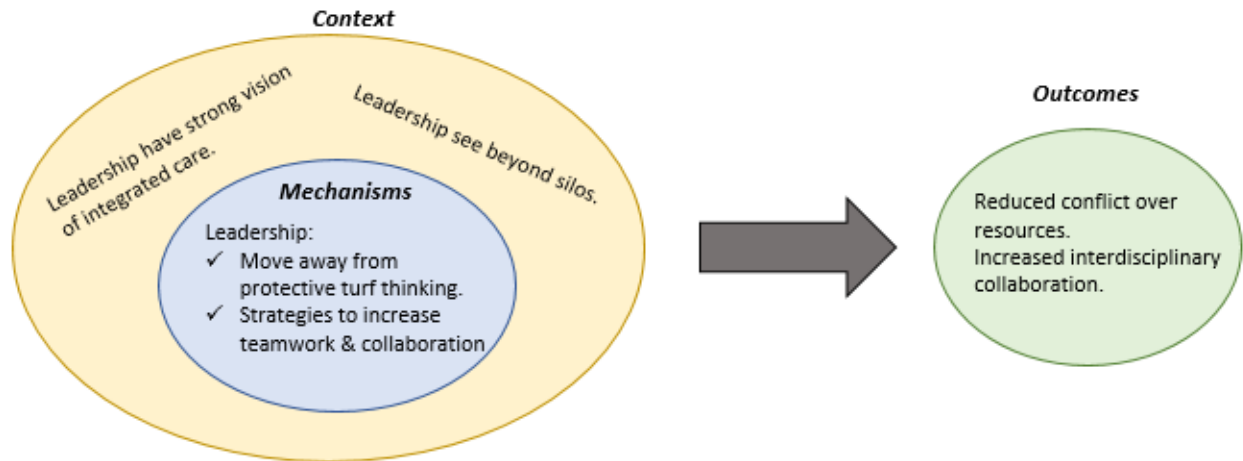


Micro level (Leadership)

Context: Leadership able to think outside silos with a strong understanding of the vision of integrated care.

Mechanisms: Leadership can assign resources as needed; there is a move away from protective turf thinking. Strategies are designed to build a sense of teamwork and increase collaboration.

Outcomes: There is a changed culture of care with reduced leadership conflict over resources and increased interdisciplinary collaboration.



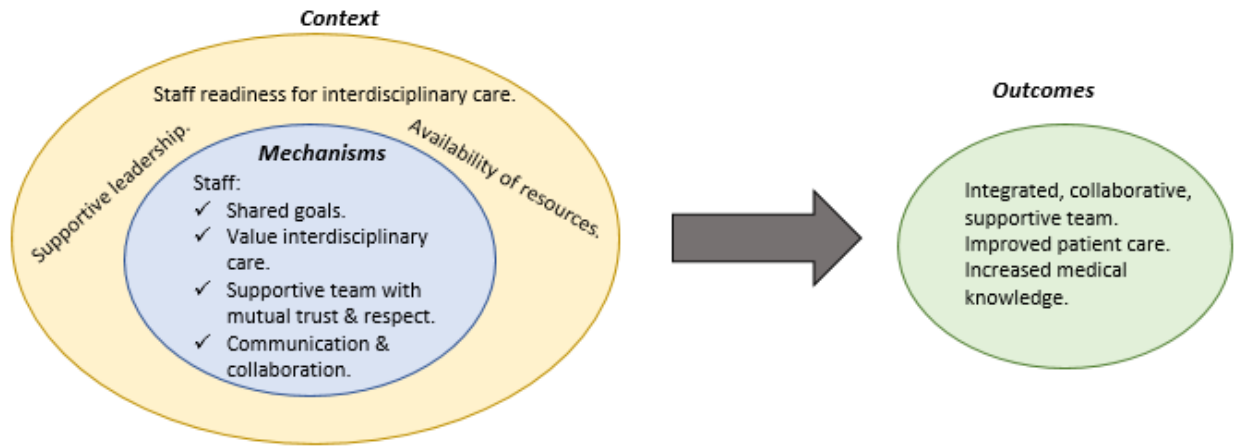
Micro level (Team)

Context: Supportive leadership who utilize intentional team-building strategies and are committed to fostering interdisciplinary collaboration. Healthcare professionals are ready for team-based care. Availability of resources to reduce workload where possible.

Mechanisms:

- ✓ People have shared goals and value teamwork and interdisciplinary care. They see the changes as helpful and valuable in improving patient care.
- ✓ People feel part of a supportive team where everyone's opinion is respected.
- ✓ People know each other and find it easy to communicate and collaborate.
- ✓ People trust each other and are able to depend on others to get things done.
- ✓ Providers look beyond their own scope of practice to see the whole patient picture and are adaptable and creative in finding solutions.
- ✓ Providers are aware of others' roles and responsibilities and how they interact with each other.

Outcomes: Integrated, collaborative, supportive team working to the top of their scope and providing coordinated care. Increased team and medical knowledge, improved patient care, including patient assistance with navigation of services and management of complex needs.

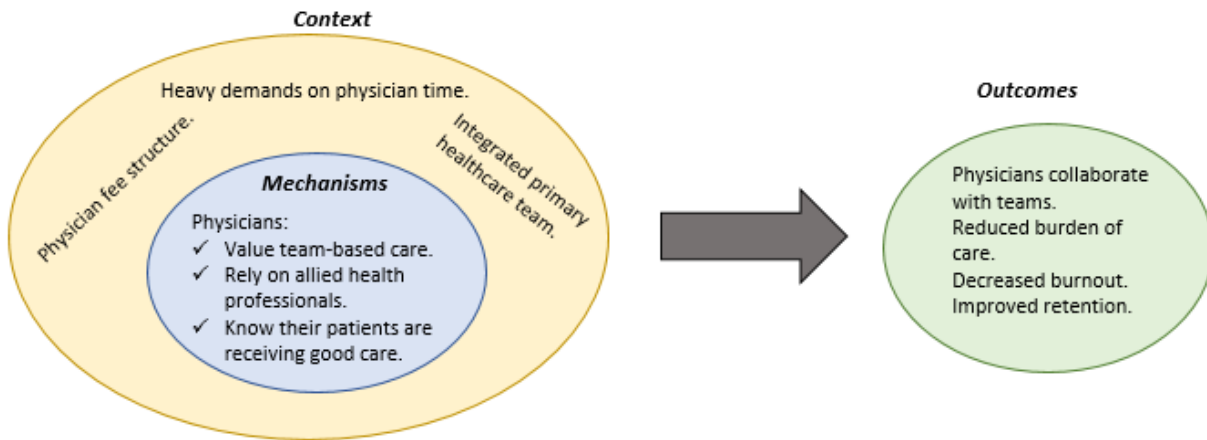


Micro level (Physicians)

Context: C₁: There are heavy demands on physician time. C₂: The compensation structure facilitates team-based care. C₃: A collaborative primary health care team exists that provides integrated care to patients.

Mechanisms: Physicians see team-based care as valuable and helpful. Physicians are able to rely on the primary health care allied professional team, taking pressure off physicians to find resources for their patients. Physicians are reassured that their patients are taken care of and are accessing the care they need outside the physician's office.

Outcomes: Physicians engage with the networks and collaborate with the team as necessary to utilize the expertise of the interdisciplinary team members. The burden of care on physicians is reduced, leading to decreased physician burnout and improved physician recruitment and retention.



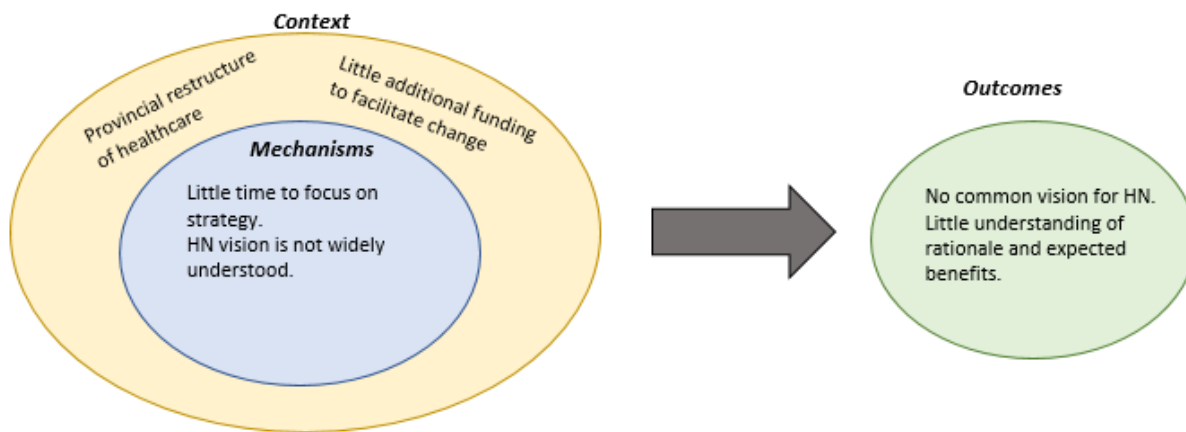
Theory of Change: Non-Success

Macro level

Context: There is a provincial drive to restructure provision of healthcare through the integration of services. There is little additional funding to facilitate change.

Mechanisms: Creation of HNs is done 'off the side of the desk' as people do not have the time to focus on strategic innovations. The vision for HNs is not widely disseminated or understood.

Outcomes: There is no common vision for HNs and little understanding of the rationale and expected benefits.

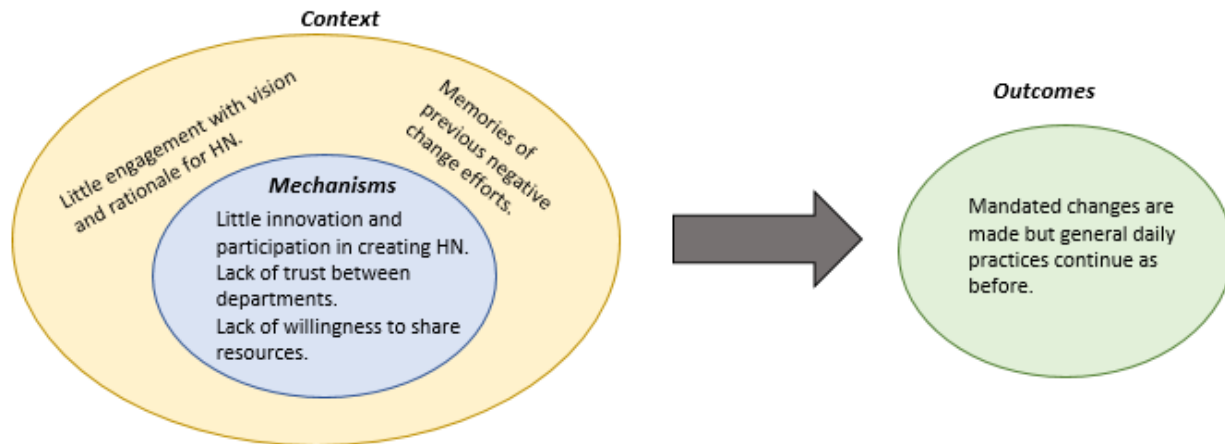


Meso level (Health Networks)

Context: There is weak diffusion or little engagement with the vision and the rationale for Health Networks. People remember previous change efforts that did not create positive change.

Mechanisms: People see the need for integrated care but do not know how to create conditions for this. There is little innovation in creating HNs and people are unwilling to participate beyond what is necessary. There is a lack of trust between departments. People hold onto resources and are unwilling to look beyond their own issues.

Outcomes: Mandated structural changes are made but people generally continue daily practices.

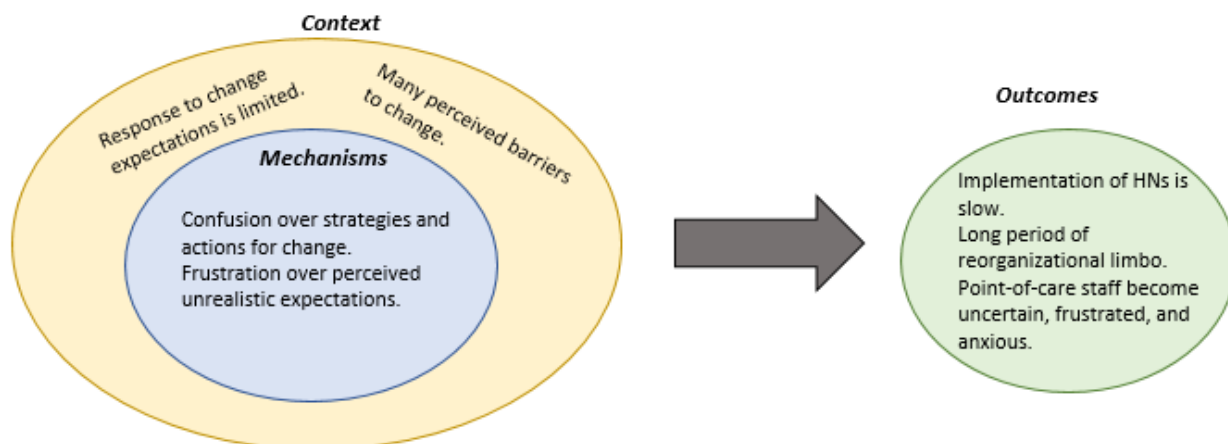


Micro level (Leadership)

Context: Response to change expectations is limited by perceived barriers, for example, staff shortages and lack of resources.

Mechanisms: There is confusion over strategies for change and actions that should be taken to implement HNs. There is frustration over perceived unrealistic expectations.

Outcomes: Implementation of HNs is slow and there is a long period of reorganizational limbo. Point-of-care staff are uncertain about changes and become anxious and frustrated.

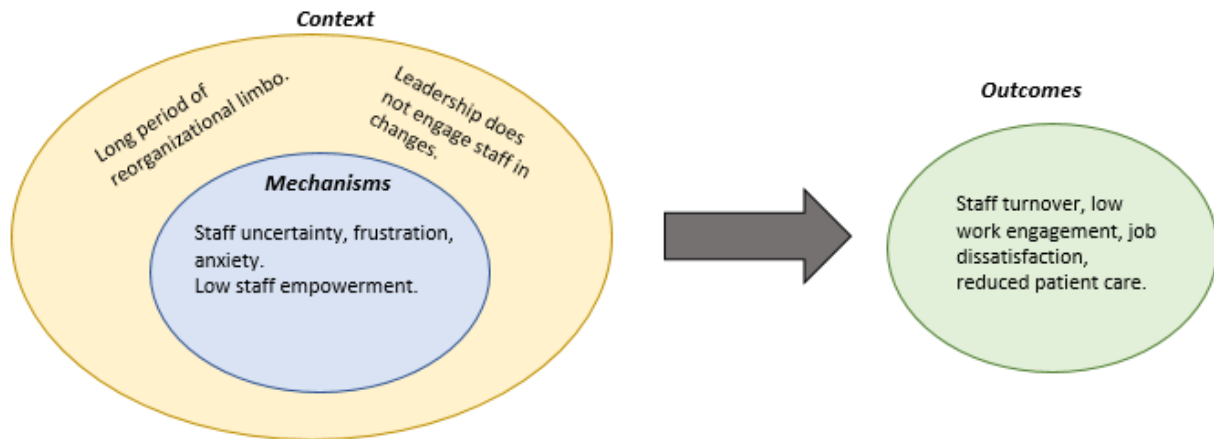


Micro level (Team 1)

Context: There is a long period of reorganizational limbo; leadership does not engage staff in changes.

Mechanisms: Staff uncertainty, frustration, anxiety, low staff empowerment.

Outcomes: Staff turnover, low work engagement, job dissatisfaction, reduced patient care.

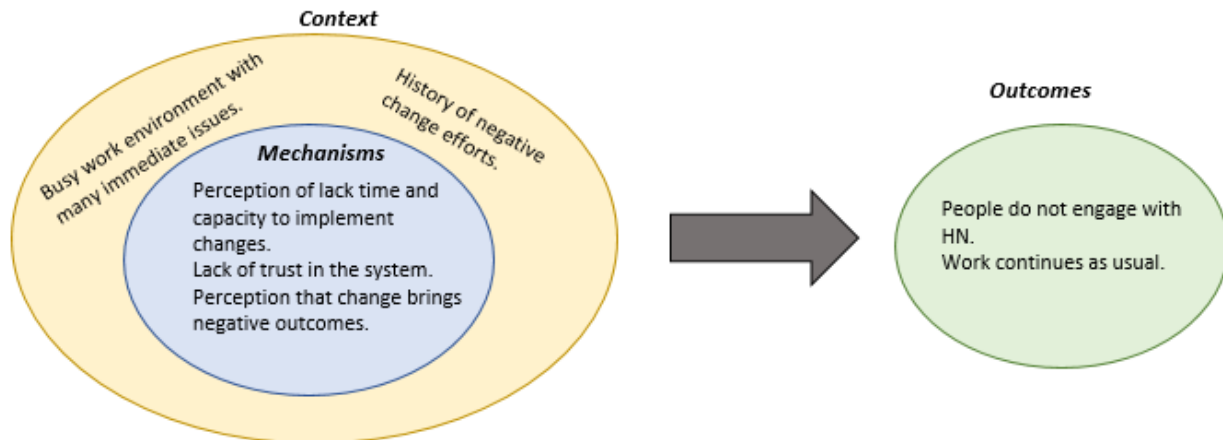


Micro level (Team 2)

Context: There is a busy work environment with many immediate issues. There is a history of negative change efforts.

Mechanisms: People feel they lack time and capacity to implement changes. People lack of trust in the system and have a perception that changes bring negative outcomes.

Outcomes: People do not engage with the implementation of HNs. Work continues as usual.

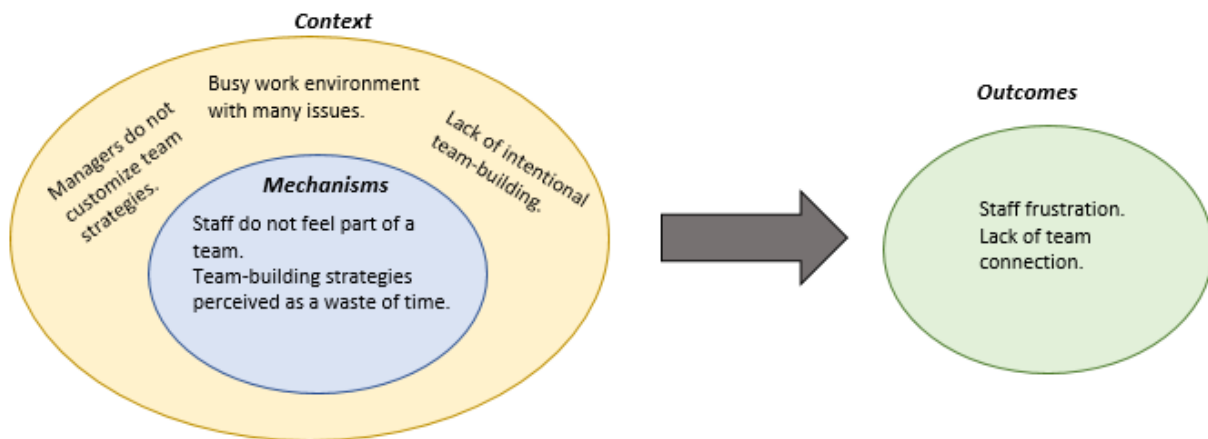


Micro level (Team 3)

Context: There is a busy work environment with many immediate issues. Managers use standardized methods and do not customize team strategies to place; there is a lack of intentional team-building.

Mechanisms: Staff do not feel part of a team and team-building strategies are perceived as a waste of time.

Outcomes: Staff frustration, lack of team connection.

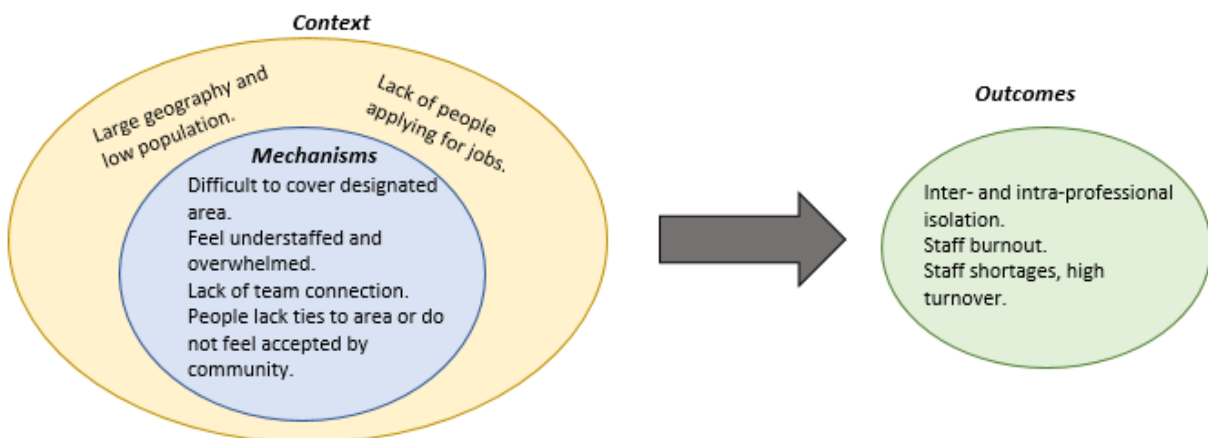


Micro level: (Team – Rural)

Context: Rural area with large geography and low population; lack of people applying for jobs.

Mechanisms: Healthcare professionals find it difficult to cover the designated area and feel understaffed and overwhelmed. They are uncertain about future staffing levels. There is a lack of face-to-face interaction and a lack of team connection. People from outside the community lack ties to the community or do not feel accepted by rural community members.

Outcomes: Inter- and intra-professional isolation (people do not know other team members and/or do not have professional colleagues): staff burnout, staff shortages, and high staff turnover.

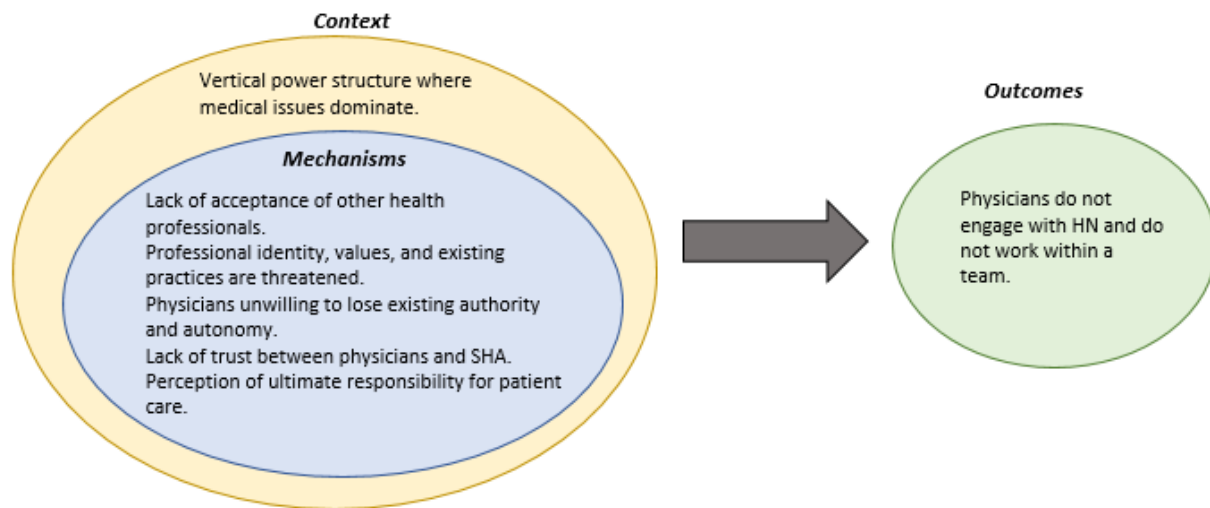


Micro level (Physicians)

Context: There is a vertical power structure where medical issues dominate.

Mechanisms: There is a lack of acceptance of other healthcare professionals. Professional identity, values, and existing practices are threatened and physicians are unwilling to lose their existing levels of authority and autonomy. Physicians see themselves as the core provider of healthcare and do not want other healthcare professionals to interfere with this care. There is a lack of trust between physicians and other healthcare providers as well as the SHA organization as a whole. Physicians see themselves as ultimately responsible for the care of the patient.

Outcomes: Physicians do not engage with Health Networks and do not work within a team.



Overarching Theory of Change

The foundation of the overarching ToC is the creation of a common vision. As a result, leaders engage with the changes and support the creation of an interdisciplinary team that has strong relationships and high levels of collaboration and communication. People have a sense of value and feasibility of the networks and shared goals for providing better care. A shared vision helps to increase physician engagement with and participation in the networks. Increased levels of trust, communication, and role knowledge help create collaborative, supportive teams. Teams that recognize the value of working with community partners work to create relationships that cooperatively provide appropriate health and prevention services to benefit the health of the community. Care that focuses on wellness and prevention and is accessible, effective, and patient-centred is likely to lead to overall improved community health.

Outlining the path to successful and non-successful outcomes can help facilitate future development of networks and increase understanding of how networks improve delivery of healthcare. The successful creation of a common vision underpins the ToC and is therefore critical to the success of HNs.

Overarching Theory of Change

