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Implementing integrated care pilot projects in hospital settings – an exploration of disruptive practices

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Abstract

Purpose – In Canada, integrated care pilot projects are often implemented as a local reform strategy to improve the quality of patient care and system efficiencies. In the qualitative study reported here, the authors explored the experiences of healthcare professionals when first implementing integrated care pilot projects, bringing together physical and mental health services, in a community hospital setting.

Design/methodology/approach – Engaging a qualitative descriptive study design, semi-structured interviews were conducted with 24 healthcare professionals who discussed their experiences with implementing three integrated care pilot projects one year following project launch. The thematic analysis captured early implementation issues and was informed by an institutional logics framework.

Findings – Three themes highlight disruptions to established logics reported by healthcare professionals during the early implementation phase: (1) integrated care practices increased workload and impacted clinical

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workflows; (2) integrating mental and physical health services altered patient and healthcare provider relationships; and (3) the introduction of integrated care practices disrupted healthcare team relations.

Originality/value – Study findings highlight the importance of considering existing logics in healthcare settings when planning integrated care initiatives. While integrated care pilot projects can contribute to organizational, team and individual practice changes, the priorities of healthcare stakeholders, relational work required and limited project resources can create significant implementation barriers.

Keywords Integrated pathways, Chronic care, Management of change, Integrated care, Continuity of care, Policy implementation

Paper type Research paper

Introduction

Efforts to reduce the siloing of physical and mental health services are often informed by integrated care principles and practices aimed at improving patient experience and increasing system efficiencies. Integrated care can be broadly defined as a "set of ideas and principles that seek to better co-ordinate care around people's needs" (Goodwin, 2016). The principles of integrated care prioritize patients/citizens as stakeholders in health and social care systems and highlight the importance of patients' values, needs, preferences and shared decision-making involving patients, families and healthcare providers (Checkland *et al.*, 2018a). Integrated care approaches are especially salient when addressing the management of multimorbidity that includes both physical and mental health conditions (Mercer *et al.*, 2012), which are not always optimally managed in a fragmented health services environment (Bullock *et al.*, 2017). The siloed treatment of physical and mental health conditions has negative implications for patient outcomes, care experiences and health system costs (Naylor *et al.*, 2016).

In the province of Ontario where the study setting is located, the importance of integrated care was highlighted as a key policy and practice reform in recent Ministry legislation and service redesign guidelines (Baker and Axler, 2015; Kuluski *et al.*, 2016). While integrated care priorities are reflected in the horizontal integration of services across 14 regional health authorities, neither hospitals nor the local health boards have control over the organization and funding of primary care physician services (Cheng Siu, 2018; Tenbensel *et al.*, 2017). Fee-for-service payment models negotiated by the medical profession's governing organization can be a significant barrier to the adoption and sustainability of integrated care initiatives at the healthcare system level (Hutchinson *et al.*, 2001). Current plans to further reform the province's service delivery system are centred on the creation of Ontario Health Teams where hospitals may play a lead role as "integrated care hubs", coordinating services with the community, across sectors and within the hospital for a defined population (Bhatia *et al.*, 2019).

Integrated care initiatives are increasingly implemented in hospital settings as a strategy to introduce and explore service innovations to improve patient-focussed care, patient outcomes and system efficiencies (Bartram *et al.*, 2020; Bhatia *et al.*, 2019). Historically, hospitals have provided acute, linear, episodic care that poorly aligns with the needs of patients managing multiple chronic conditions (Erskine *et al.*, 2018). Characterized by complex governance structures that can interfere with local integrated care strategies, hospitals are under intense pressure to improve the quality of services while simultaneously reducing costs (Round *et al.*, 2018; Van Den Broek *et al.*, 2014). Additionally, tensions between the administrative priorities of hospital management and the clinical and financial concerns of healthcare providers emerge when "attempts to change the way work is organized confronts a web of different stakeholders and professional cultures" (Bartram *et al.*, 2020, p. 43). Established workplace policies and rules can interfere with the acceptance of service innovations such as the introduction of novel clinical roles coordinating hospital and community-based care (Bhatia *et al.*, 2019; Geerligs *et al.*, 2018; Riordan *et al.*, 2019). Hospital-based physicians may be initially resistant to service innovations that potentially undermine

their independence and authority, particularly when limited healthcare resources are available (Dent *et al.*, 2013). As a result of these professional and managerial tensions, temporary, integrated care pilot projects are often implemented in hospital settings as a local reform strategy to mobilize physician leadership and increase buy-in for innovative service delivery models (Storey *et al.*, 2019). However with limited third-party evaluations available, little is known about the potential roles for hospitals in integrated care systems (Bhatia *et al.*, 2019; Glasby and Miller, 2020).

This qualitative paper reports on the experiences of healthcare providers supporting three hospital-based pilot projects directed towards improving the integration of physical and mental health for patients and their families. In doing so, we explore tensions and opportunities reported by hospital staff when introducing integrated care models in a highly complex bureaucratic, clinical and institutional environment. Although we are reporting on local experiences, we believe that our findings will be useful to organizations in other jurisdictions that are implementing integrated care projects.

Study setting

The three pilot projects analyzed here were supported by the Medical Psychiatry Alliance [MPA], a multi-year collaborative partnership involving three hospitals (community, psychiatric and paediatric) and a local university dedicated to improving care for patients who suffer from physical and psychiatric conditions. Each pilot project introduced integrated care service innovations that brought together physical and mental health services in ambulatory and inpatient settings for distinct patient populations including adolescents, adults and seniors. Although the projects included different intervention designs, they shared a common foundation through a focus on improving the integration of physical and mental health services to improve care coordination, patient experience and reduce avoidable hospital admissions/readmissions. The Paediatrics Diabetes (PD) project, based in a provincial diabetes clinic, provided youth between the ages of 12 and 18 with regular mental health screening and check-ins and targeted treatment for patients reporting mild depression and/or anxiety. Based in a cardiac care unit, the Delirium Prevention and Management (DPM) project provided daily screening to detect delirium and patient activation strategies to prevent delirium. The Community-Based Seniors (CBS) project led by care managers liaising with patients, geriatric specialists and primary care physicians provided home visits, care coordination, behavioural activation therapy and systematic case reviews (see Table 1).

Table 1. Overview of pilot projects integrating physical and mental health services

Project	Community-based seniors (CBS)	Delirium prevention/ management (DPM)	Paediatric diabetes (PD)
Purpose	For community-based seniors with a chronic physical health condition and mild-to-moderate depression/anxiety	To reduce and prevent the incidence, severity, duration of delirium for adult and senior inpatients	To implement a holistic care model for the treatment of adolescents (13–18 years) with type 1 diabetes and depression
Integrated care focus	Integration of mental health services in primary care settings through improved leveraging of interprofessional geriatric expertise	Increased collaboration between physical and mental health clinicians in providing patient-centred acute care	Moving from a biomedical model to a whole person and family approach in the management of type 1 diabetes

(*continued*)

Project	Community-based seniors (CBS)	Delirium prevention/ management (DPM)	Paediatric diabetes (PD)
Setting	Primary-care based, community outreach and referrals coordinated by a hospital-based Seniors' Mental Health Programme	In-patient hospital cardiac care unit as pilot site with plans for hospital-wide expansion	Outpatient, hospital-based ambulatory provincial paediatric diabetes clinic
Service integration and innovation	Time limited (16 weeks) integrated geriatric medicine and psychiatry intervention implemented by a care manager liaising between patients, primary care, geriatric medicine and psychiatry. Key features: home visits; integrated care plans; behavioural activation therapy; systematic case reviews	Evidence-based delirium assessment, prevention and management strategies including daily delirium screening, patient activation practices and environmental sensory cues (e.g. appropriate lighting for time of day). Staff provided with ongoing interprofessional delirium team training	Screening, monitoring all adolescent patients with a disease-specific quality of life and emotional well-being tool Developing collaborative treatment to target plans during systematic case reviews with telepsychiatry support for diagnosis and treatment
Integrated care team	care managers (nurse, occupational therapist or social worker), geriatrician, geriatric psychiatrist, family practice representative, project coordinator	geriatrician, psychiatrist, nurse practitioner, occupational therapist, project manager	diabetes educators (nurse, registered dietician), social workers, paediatric endocrinologists and psychiatrist, project manager

Table 1.

Methods

Study design

This evaluation engaged a comparative case study approach grounded in a qualitative descriptive design (Sandelowski, 2000). Joint project learnings were anticipated as all three projects were based in a community hospital setting and shared overarching integrated care goals. By including common data collection and comparative analysis strategies within a single study design, the evaluation supported the identification of both project-specific and cross-project learnings (Webster *et al.*, 2015). Data collection occurred at two time points: one year following project launch and a year later when the intervention had matured. In this paper, we report on the perspectives of healthcare providers during the early implementation phase when challenges associated with the introduction of practice innovations aiming to improve the integration of mental health and physical health services emerged.

Recruitment and data collection

Following Research Ethics Board approval at Trillium Health Partners, staff contact information was provided by the three project leads and potential participants were contacted by email. Individuals who expressed interest in participating in the evaluation were provided with study information packages. After receiving informed consent, the research coordinator scheduled a 1-h in-person or telephone interviews. Semi-structured interview guides were developed for the gathering of common information across all three pilot projects, while also encouraging participants to share additional project-specific insights. Key topic areas included in the healthcare provider interview guide were: (1) intervention components, processes and theories of change; (2) healthcare professional experiences with

project implementation; and (3) perceived individual, organizational and local factors that facilitated or interfered with project implementation. The interviews were digitally recorded and professionally transcribed. Following a review of the transcripts for accuracy and to remove identifiers, the transcripts were entered into Atlas-Ti, a qualitative data management software program.

Data analysis

Thematic analysis was used to identify themes within and across the data (Braun and Clarke, 2006). The qualitative team [EM, PD, JS, SM, MM] read a purposive sample of transcripts independently to identify potential codes. The researchers then met to compare their independent analysis and develop a coding framework. Four Research team members [PD, JS, MM, SM] then coded the remaining interviews and documents using this coding framework. Codes were combined into themes during a series of team meetings in which the relationships between the themes were explored and summarized. The team maintained an audit trail of meetings, analytical questions that arose and decisions that were made to enhance transparency (Tobin and Begley, 2004).

Results

In total, 24 healthcare providers from the three project sites agreed to participate in the study (Table 2). Our sample included nurses, social workers, physicians, allied health professionals and managers, with the majority of participants in their thirties and forties and having more than ten years of clinical experience. In total, 20 in-person and four telephone interviews ranged in length from 40 to 120 min with an average duration of 50 min. Interviews took place one year following project launch dates. The research team identified three key cross-cutting themes that highlighted the disruption created by integrated care pilot projects during the early project prototype phase: (1) integrated care practices increased workload and impacted clinical workflows; (2) integrating mental and physical health services altered patient and healthcare provider relationships; (3) the introduction of new skills and integrated care practices disrupted healthcare team relations.

Category	Grouping	*n 24*
Sex	Male	4
	Female	20
Age	30–39	11
	40–49	7
	50–59	6
Healthcare discipline	Physicians	4
	Nurses	8
	Social workers	4
	Allied health professionals	5
	Managers	3
Years in practice	>5	3
	5–9	6
	10–19	11
	20–29	4

Table 2.
Sample characteristics

Integrated care practices increased workload and impacted clinical workflows

Participants from all pilot project teams described multiple ways in which the integrated care interventions introduced new practices that increased the clinical workload and disrupted the workflow of usual care. Care team members reported challenges in maintaining planned work activities and clinical schedules with the addition of new tasks and care requirements. In particular, members of the paediatric diabetes team discussed how the framework of integrated care and a holistic approach impacted workload and workflow. For example, predictions about the clinical time needed to see individual patients in the diabetes clinic were impacted by the addition of a mental health focus. The mental health screening tool administered to teen patients with diabetes was described by participants as "opening up a Pandora's Box", as staff could not predict which patients might be experiencing anxiety or depression and require an extended appointment time within a busy clinical setting:

> It's not knowing what the teens will say. So we might have appointments every 20 min at the clinic. We do not know if two of the teenagers that morning might tell us they're feeling depressed, and if they do, then everything else stops so we can talk about that. So it can throw the flow. (PD-2, social worker)

Healthcare providers associated with all three initiatives noted the impact of existing provider service funding models on the implementation of more holistic, integrated care approaches. The CBS project planned to include referring primary care physicians in weekly, multidisciplinary patient case reviews. This proved to be particularly challenging with solo family practitioners who, unlike family health team physicians, were completely reliant upon fee for service funding, may not have been familiar with billing codes for group telephone consultations or faced difficulties in scheduling a telephone meeting in busy, clinical practices. In addition, telephone consultations are poorly compensated within the current provincial health insurance plan's physician fee schedule:

> We would [like to] have the family doctors themselves involved in the case conference. That's much more feasible for somebody in a family health team because they're compensated in a certain way where they can take that time, whereas the solo practitioner is fully compensated only if the patient's in front of them; so it's difficult to ask them to take an hour of their day to do something that they're really not going to be compensated for, and that's just the reality of our healthcare system. (CBS-6, physician)

Participants from the DPM project team reported that perceived increases in workload as a result of a pilot project were initially met with resistance from frontline staff. The frontline staff, predominantly nurses, experienced the pressures of managing a heavy workload and completing scheduled activities in a busy hospital unit. The pilot project increased the workload of frontline care providers with the introduction of additional tasks including the screening of all patients for delirium twice daily, getting patients out of bed to sit in chairs for meals and assisting patients with regular hallway walks. While cardiac unit nursing staff recognized the importance of delirium screening, there was frustration that attending physicians and specialists from other departments were difficult to engage when reporting screening results. Frontline nursing staff described their professional roles in relation to cardiology specialization and some initially resisted adopting a more holistic, integrated patient care approach. When first implementing patient activation strategies, there was considerable pushback from busy frontline staff:

> When we first started I did get some comments on the cardiology unit. "This is cardiology, we save lives. We do not have time." There was pushback when we started talking about, for example, getting your patient up in a chair for every meal. "Well who's going to do that? Is that going to be me? And how am I supposed to watch them?" And you know, it's not unreasonable. They're asked to do

> 40 bazillion screening tools and now we're saying, you know, play bingo with your patient. (DPM-6, nurse)

Integrating mental and physical health services altered patient and healthcare provider relationships

The pilot projects' integrated care goals created shifts in the relationships and dynamics between healthcare providers and patients and between patients and family caregivers. Through a series of stakeholder engagement meetings, patients and families had been engaged in developing a new, integrated care model of paediatric diabetes care. Although families endorsed a more holistic approach to paediatric diabetes management, healthcare providers observed that some family caregivers initially experienced discomfort with redesigned services where young people participated independently in guided clinical interviews:

> It also gives a child a chance to answer, so in appointments with a parent there, the parent is often doing a lot of the talking. And this [intervention] really gives the floor to the child and we do it privately, we talk to them about it privately, we ask if they want us to share with their parents. This changes the dynamics to the child being given more of a voice as well. (PD-4, nurse)

Participants from the CBS pilot project reported supporting patients and families in developing their own self-advocacy skills as an important strength of integrating mental and physical health services. An important component of the project was *Engage* (Alexopoulos *et al.*, 2016), a behavioural activation programme to mediate depression in seniors and to help patients develop self-advocacy skills when identifying care goals and priorities during appointments with family physicians. Project team participants reported that most patients appreciated the therapeutic, goal-setting, care coordination and advocacy features of the programme and that relationships with primary care providers improved as patients became more effective in communicating their values, needs and preferences:

> We're actually trying to give them some possible strategies and solutions to work with .... I mean I see patients who feel listened to, who have a stronger relationship with their family doctor, the family doctor has a better understanding of all of their issues that they're struggling with at home so that words like non-compliance do not come up anymore. (CBS-1, social worker)

Participants also observed the impact of the DPM project on healthcare providers and families. Initially, the project team encountered resistance to the intervention as it was perceived as creating additional work and falling outside of the discipline of cardiac specialty care. Over time, the healthcare providers on the cardiac ward developed confidence and skills in DPM, experienced the resultant benefits for patients and families and became champions of the intervention. As a cardiac nurse observed:

> And then when you see like when they are implementing their prevention and even treatment strategies, like getting patients into the chairs, you can see where even the patients are happier. "Oh, it's so nice to be out walking in the hallway." Like those little comments that are being said out there. Like seeing families engaged .... And it brings on more conversations between the nurses who are managing the patients and their families. (DPM-5, nurse)

The introduction of new skills and integrated care practices disrupted healthcare team relations

Participants reported that additional time was required to acquire and apply shared, integrated care disciplinary knowledges and skill sets. For all three project teams, the acquisition of new skill sets and practices took more time than anticipated during the pre-

launch, intervention design and planning phase. Team members with the PD project discussed the value of a shared, holistic approach to diabetes management and how it changed team dynamics. The integrated care logic brought together the physical and mental health components of diabetes care and introduced new work activities such as systematic patient reviews and rounds that included discussions related to mental health screening results. A few months after the project launched, the clinic's permanent staff, including nurses and dietician, advocated for more involvement with the mental health component of this intervention:

> In the beginning it felt like it was just going to be owned by these guys [social workers], and I think it came from a good place because they just did not want to put more work on the nurses. . .. I just felt like, well you cannot just see social work because that's half of the person; the diabetes part has to be managed too. We were saying, "You've got to have us in there too!" (PD-5, nurse)

The CBS project leveraged the expertise of a geriatrician and geriatric psychiatrist supervising care mangers in reviewing patient care and making treatment recommendations during systematic case reviews. In this model, care managers had to develop skills in presenting patient cases and liaising between patients, family caregivers, the geriatric specialists and primary care physicians:

> So you cannot just take a variety of healthcare workers and put them together and say, "Here, go work collaboratively." You actually have to help everyone develop their integrated care competencies. So one example was in our new model, the geriatricians and the geriatric psychiatrists were actually not seeing the patients, they supported the patient care through clinical supervision of the care managers who then worked with the MRP, which is the family doctor, to deliver the care. (CBS-4, allied health)

When working in new ways that are more collaborative, holistic and person-centred, more time and training are required so that frontline staff can understand their roles, responsibilities and goals of different disciplines and how they can inform clinical practice. For example, with the DPM project, nurse participants reported that they did not have a full understanding of the work of occupational therapists and how their work, focussed on patient activation, could reduce clinical work demands. This project team invested resources in ongoing education about interprofessional delirium management and prevention and the potential to improve healthcare provider experiences and patient outcomes:

> And education because a lot of people still do not know who the delirium occupational therapist is, or what it is she does. So just education around the staffing and their roles and what the purpose of the project is. If we prevent delirium we actually reduce the nursing caseload, because patients are not confused and do not have to be under direct supervision. They're not falling. They're not wandering the hallways. (DPM-9, allied health)

Discussion

We have applied an institutional logics framework to interpret our study findings and further contextualize the implementation challenges and opportunities associated with the integrated care pilot projects in our hospital. Friedland and Alford (1991) introduced the concept of institutional logics into organizational studies research to describe how overarching belief systems grounded within social institutions shape the cognitive frameworks and behaviours of actors working in shared organizational communities or professional fields. Competing and layered institutional logics, evident in hospital settings, reflect multiple and potentially conflicting demands such as increasing the quality of patient-centred care while simultaneously reducing costs and accommodating the diverse professional interests of the healthcare labour force (Van den Broek *et al.* 2014). By

engaging this framework, we were able to explore the pilot projects in relation to shifts and alterations in guiding logics and belief systems that occur through cumulative, everyday practice changes (Cain, 2019).

Historically, the dominance of the institutional logic of the medical profession in Canada, as in many other international jurisdictions, is reflected in policies and practices where appropriate care for patients and government funding are informed by physician-determined needs and authority (Reay and Hinings, 2005, 2009). Core dimensions of this *professional* institutional logic include the primacy of the patient–physician relationship and clinical and financial autonomy related to treatment decisions (Besharov and Smith, 2014; Bévort and Suddaby, 2016; Checkland *et al.*, 2018b; Currie *et al.*, 2012; Kitchener and Exworthy, 2008; Martin *et al.*, 2015, 2017). Since the 1970s, however, escalating healthcare costs associated with factors such as the introduction of new technologies, an increasingly complex division of healthcare labour and the influence of evidence-based medicine on clinical decision-making have contributed to the emergence of a *managerial* logic prioritizing greater administrative controls on healthcare services to improve system efficiencies (Checkland *et al.*, 2018b; Currie *et al.*, 2012; Gadolin, 2018). More recently, *integrated care* is described as an emergent institutional framework or logic (Shaw *et al.*, 2017) that blends the focus of professional healthcare on quality, patient-centred care with the managerial and network priorities of efficient and cost-effective services that are importantly coordinated around patient needs, values and preferences.

The introduction of integrated care practices in our hospital challenged existing time and service assumptions based on a managerial logic that informed hospital planning and administrative tasks such as staff scheduling and unit work plans. For example, DPM project participants observed that low staffing levels and hospital surges impacted patient activation strategies that required staff to incorporate new collaborative work tasks into their daily shifts. This observation aligns with findings from a study in Sweden where the authors observed that managerial logics and priorities often dominated when holistic models of psychiatric care were first introduced in hospital settings (Arman *et al.*, 2014). Our evaluation results highlight how the focus on more holistic, patient-centred care also led to practice changes that could, at times, conflict with the compensation rules and understandings of fee-for-service physicians. In this context, the logic of the medical profession and the significance of clinical and financial autonomy are a theme resonating with our study findings. Both the CBS and PD projects demonstrated the challenges of introducing service innovations into healthcare settings where existing compensation arrangements for physicians are structured around a fee-for-service payment system supported by powerful medical associations (Bartram *et al.*, 2020; Reay and Hinings, 2005). The need to ensure that appropriate financial compensation models are in place for clinicians, as well as mechanisms that protect clinician time, is widely discussed in the integrated care literature (Domingo *et al.*, 2019; Glasby and Miller, 2020; Hodemakers *et al.*, 2019).

Hospitals are complex, heterogeneous organizations where clear communications between providers, departments and allied organizations are critical to the success of patient-centred interventions, especially where collaboration is required across different clinical disciplines, departments and sectors (Bhatia *et al.*, 2019; Bartram *et al.*, 2020; Geerlig *et al.*, 2018). In this evaluation, engaging patients, families and staff around the purpose and mission of the new model of care could support improved communications. For example, the Paediatric Diabetes unit is a well-established clinic with an experienced, core staff and a legacy of strong, ongoing relations with patients, families and service providers. This established patient, family and healthcare provider community was involved in early discussions about the integrated care rationale for a more holistic approach to type 1 diabetes (T1D) care and these shared understandings supported effective pilot project communication strategies. Of the three projects, the PD team reported the most success in creating a community of practice and culture informed by integrated care goals. Conversely, the DPM team reported that intervention communications did not always resonate when shared with

other hospital departments and external healthcare providers. Some staff reported frustration when communicating positive delirium screening results to specialists in other areas of the hospital who were not directly engaged in the intervention but involved in a patient's care. While physicians often play a pivotal role in organizational change efforts, they also tend to identify with their own profession rather than the hospital and this can be challenging when introducing integrated care models that empower patients and families while bridging professional and managerial logics (Bartram *et al.*, 2020).

Traditional institutional logic perspectives often engage a top-down analytic approach with less attention paid to the routine experiences of professionals and how innovations are negotiated, mediated and transformed through everyday frontline practices (Hampel *et al.*, 2017; Lawrence *et al.*, 2011; Suddaby and Viale, 2011; Zilber, 2013). Institutional work perspectives may provide insights into the work of frontline hospital staff engaged in pilot projects as they transform practice and the institutional arrangements they are embedded in (Checkland *et al.*, 2018a; Vink *et al.*, 2019). Study findings highlight early implementation challenges when introducing integrated care innovations in a hospital setting and provide insights into the intense institutional work required of frontline staff in efforts to transform models of care. Lawrence and Suddaby (2006, p. 215) conceptualize institutional work as "the purposive action of individuals and organizations aimed at creating, maintaining and disrupting institutions". This perspective focusses on how healthcare workers respond to their local situation and embedded meaning structures and actively engage in disrupting, refining and aligning their practice approaches with existent and/or emergent care logics (Cain, 2019; Creed *et al.*, 2014). The introduction of novel practices was evident, for example, in the CBS project where care managers were trained to lead patient case review sessions traditionally led by physicians. Similarly, nurses and allied health members of the PD team advocated to be included in multidisciplinary training and psychiatric case reviews so they could play a more meaningful role in supporting youth mental health needs. The importance of building relationships when planning and implementing integrated care models was discussed by our participants as largely unanticipated and aligns with Cloutier *et al.*'s (2015) insight that building trust, connectivity and collaboration are key to implementing local practice reforms. Continuous educational support is a prerequisite for integrated care models, especially when more patient-centred approaches alter the power dynamics of clinical encounters (Uittenbroek *et al.*, 2018).

Across the three integrated care projects, nurses, social workers and other allied health professionals, as well as physicians, assumed important leadership roles. Study findings about multidisciplinary project leadership may augment research highlighting physician champions as key to the successful introduction of new models of care (Bartram *et al.*, 2020; Shaw *et al.*, 2017). The institutional work lens shifts attention away from the "dramatic actions of the heroic entrepreneur to the small worlds of institutional resistance and maintenance in which institutionalization and institutional change are enacted in the everyday getting by of individuals and groups who reproduce their roles, rites, and rituals at the same time that they challenge, modify, and disrupt them" (Lawrence *et al.*, 2011, p. 57). Institutional work perspectives explore how and why actors engage in changing and reshaping organizational practices and cultures and the facilitators and challenges they encounter when introducing alternative institutional logics (Hampel *et al.*, 2017). The strategies used by frontline care workers when implementing new integrated care models may provide important insights for clinicians and managers in their everyday work as practice innovators. The DPM team, for example, facilitated short, ongoing education and training sessions so that day and evening unit staff could develop skills in delirium assessment and implementing collaborative patient activation strategies.

From an institutional work perspective, integrated care pilot projects may be seen as "proto-institutions", that is, practices, rules or technologies that are neither well-established nor widely disseminated (Lawrence *et al.*, 2002). Pilot projects may create a space in hospital

settings where routine processes can be temporarily disrupted (Vink *et al.*, 2019). In their review of the health services redesign literature, Vink *et al.* (2019) relatedly observe that project work is important through helping to visualize key aspects of healthcare and the "rules of the game" that are often invisible and taken for granted in everyday practice. In fact, pilot projects and quality improvement interventions are often a preferred approach for introducing and trying out new service innovations in hospital settings (Bhatia *et al.*, 2019; Bartram *et al.*, 2020; Jespersen, 2013). Söderlund and Sydow (2019) note that by introducing time-limited, temporary projects in bureaucratically complex organizations, interventions are subjected to less scrutiny than if posited as permanent practice changes.

Strengths/limitations

Through bringing a qualitative evaluation approach to the exploration of early implementation experiences and applying an institutional logics framework, this study allowed for in-depth comparative understandings of project-specific and cross-cutting contextual factors that shaped the frontline experiences of clinicians engaged in implementing integrated care initiatives. A limitation of this study is that some participants may have felt demands to report positive findings or to minimize the reporting of difficulties they encountered. As reported in other pilot project evaluations (Mansfield *et al.*, 2018), some participants may feel invested in a project's success, due to career and future employment implications and particularly in a large healthcare organization. Further, we have reported here on early evaluation findings and anticipate that some of the initial challenges reported by participants resolved over time. Additionally, future evaluations should include organizational leaders and administrators as this could help to further inform our knowledge of the challenges and opportunities associated with integrated care pilot projects across organizational hierarchies. Future evaluation studies could also include a variety of hospital sites to achieve a more robust understanding of early integrated care implementation lessons.

Conclusions

Our qualitative study highlights how integrated care models, when first introduced in healthcare settings, may disrupt existing institutional logics and require extensive engagement and service innovation work by frontline service providers. Findings demonstrated that innovative integrated care practices can challenge and disrupt professional and managerial logics embedded in a hospital setting and that temporary pilot projects are a strategy to trigger service reform, collaboration and change. This evaluation also highlights the considerable institutional work associated with implementing integrated care models in a hospital setting that are based on rules, beliefs, values and assumptions that may not align with existing priorities and institutionalized practices of other organized healthcare stakeholder interests. The implementation of integrated care pilot projects can contribute to changes in clinical practices and culture informing organizational, team and individual behaviours. However, pilot projects, by themselves, cannot overcome systemic barriers that create significant challenges to the realization of reforms breaking down the siloed delivery of physical and mental healthcare. A consideration of existing logics in healthcare settings is critical to the planning and implementation of hospital-based integrated care initiatives.

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