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CONFERENCE ABSTRACT

Providers perspectives on mandated local health networks for older adults in the province of Quebec, Canada

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Paul Wankah[1,2], Mylaine Breton[1,2], Louise Belzile[1,3], Dominique Gagnon[4], Yves Couturier[1,3]

1: Université de Sherbrooke, Canada;

2: Centre de Recherche de l'Hôpital Charles-Le Moyne, Canada;

3: Centre de Recherche sur le vieillissement du CIUSS-CHUS de l'Estrie, Canada;

4: Université de Québec en Abitibi-Témiscamingue, Canada

Background: In 2004, the government of Quebec made major reforms in the organisation of its health system by implementing Local Health Networks (LHNs) focused on the needs of various sub-populations. Informed by two prominent pilot projects (1, 2), the Ministry of Health and Social Services aimed at improving the continuity, coherence, quality and efficiency of health and social services by mandating the implementation of LHNs for older people with complex needs in its territory following a co-ordination model of integration (3). Understanding how mandated innovations are adopted and routinized in different contexts may give insights on which components of the innovation work where and why they work. Hence this project questions how and why does the implementation of LHNs for older adults vary between three LHNs in Quebec according to the perspectives of providers?

Theory/Methods: A multiple case study, consisting of a highly urban, an urban and a rural setting. Semi-structured interviews of providers (n=29) and key documents were collected. Analysis done with the NVIVO software was based on themes inspired by The Rainbow Model of Integrated Care(4) which distinguishes 59 constructs in six interlinked integration dimensions: clinical, professional, organisational, system, functional and normative integration.

Results: Variable implementation of components of LHNs in all three cases. Providers reported great variability in the implementation of clinical integration components such as the elaboration of individualised care plans for patients, care coordination through case management, and the engagement of patients/caregivers in the organisation and delivery of care. Providers experienced professional integration through the usage of multidisciplinary client evaluation tools, which facilitated inter-professional collaborations. Merging organisations of the LHNs and creating various inter-organisational strategies such as liaison nurses, aimed at promoting organisational integration, ensured continuity of services. Usage of various health information systems by providers eased functional integration,

communication and collaborations between partners. Pertaining to system integration, the three cases shared the same political, economic and social climate.

Discussion: Variability in the implementation of LHNs in the cases studied may be attributed to several factors. Characteristics of the local context, such as lack of appropriate personnel resulted in the rural LHN not instituting case managers or liaison nurses, a problem not faced in the other two cases. Characteristics of the innovation, such as the cumbersomeness of the multidisciplinary client evaluation tool resulted in some providers not using it in their LHNs. Providers often worked with multiple unaligned health information systems which varied within and between cases due to inappropriate managerial decisions. Mostly, providers ensured optimal care delivery to their clients by adjusting to these variations.

Conclusion: The breadth and depth of different components of LHNs varied across the cases. Providers need flexibility and adaptability while carrying out their duties.

Lessons learned: Different factors may influence the implementation variability of LHNs, which in turn influences the way providers perform their duties.

Limitations: Only one perspective was studied, and these findings may be generalised only to similar LHNs.

Suggestions for future research: Effects analysis of the implementation of the LHNs for older people.

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