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CONFERENCE ABSTRACT

Contextual Differences for Implementation: Two Primary Care Settings in Alberta, Canada

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Introduction:

Evaluating the feasibility of a research-based model of integrated primary care requires careful attention to implementation. In this poster we present findings from the Alberta arm of a national study funded by the Canadian Frailty Network. Primary health care professionals in two Primary Care Networks (PCNs) implemented a program to support risk screening, patient engagement and shared-decision making, and the matching of community dwelling older Canadians to targeted community supports. The aim is to help primary care providers identify people at risk of becoming frail and develop personalized, integrated care plans to maintain wellness. Drawing on the Consolidated Framework for Implementation Research (CFIR), we examined contextual factors influencing intervention implementation and ongoing delivery in the two participating Alberta sites.

Theory/Methods:

Researchers worked in two phases. The first phase included pre-implementation focus groups (n=15) and interviews (n=8) to provide an understanding of current care practices, identify areas of focus for implementation plans, and cultivate relationships with those implementing program tools. The second phase included a 3-hour training session with staff, followed by ongoing support, update meetings, and informal interactions with the staff. Analysis of focus groups, interviews, and field notes (NVivo 12) examined CFIR domains. Results were validated by staff implementing the program, and the research team.

Results:

Results revealed slower uptake in one site context over the other due to two aspects of inner setting 1) nurse workforce structure (Networks and Communications, specifically the formal and informal communications within an organization), and 2) system technology options (Compatibility, specifically the intervention fit with existing technological workflows and systems).

Discussion:

It is important to acknowledge that not all aspects of context can be known at the beginning of an implementation study. It is valuable to probe 'real world' considerations for different implementation sites when evaluating the feasibility of a program. By adopting ethnographic methods during the intervention planning and roll out, researchers were able to identify key CFIR constructs that added the most insight and those which needed further consideration for engaging staff and obtaining focused, in-depth feedback in a timely manner.

Conclusion:

CFIR constructs facilitate the examination of complex implementations. Our experience of testing a research-based model of integrated primary care in two Alberta sites highlighted the importance of CFIR constructs related to inner setting. In these contexts, networks and communications had a complex role to play, as well as the compatibility of technology with existing systems.

Lessons learned:

CFIR provides a framework for delving deeply into local settings and the context and mechanisms for the uptake of new processes.

Limitations:

Building trust with key informants over long distances and across organizations takes time; a closer geographical and organizational presence would have helped build understanding more swiftly across this three-year study.

Suggestions for future research:

Future research is needed on the contextual influences of implementation practices, specifically the impact of workforce organization on the capacity to engage with new tools and practices.