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CONFERENCE ABSTRACT

What does one learn from the implementation of a mandated integrated network for older adults across three different settings in Quebec

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Context: In 2004, Quebec mandated its 94 Health and social services centers to lead in the implementation of local integrated health networks. The Health and social services centers, which were created by the fusion of some public establishments (local community health centers, long term care facilities and acute care hospitals in some cases), provide a broad range of health and social services to their populations. To ensure the provision of a comprehensive continuum of care, theses Health and social services centers create partnerships with community organisations, pharmacies and primary healthcare providers of their territories. Objective: To compare the implementation of 3 mandated local integrated health networks for seniors in 3 geographical settings; highly urban, urban and rural.

Methods: This research is part of an international research program ICOACH where 3 case studies were carried out in each jurisdiction: Quebec, Ontario and New Zealand. This presentation is based on data collected from 46 semi-structured interviews of healthcare providers and managers in Quebec, as well as the analysis of official documents.

Results: The mandated networks for older adults were based on the local implementation of 9 components; 1) a joint governing board, 2) a centralized access point, 3) case management, 4) a common multidisciplinary evaluation tool, 5) an individualized service plan, 6) a common healthcare information system, 7) a geriatric team, 8) the involvement of the family physician in the community and 9) an administrator for the local network. All the main components of the local network were mandated, and several components were implemented with local variations. For instance, each local integrated network for older people had its joint governing board, but the composition and the dynamism of these boards differed considerably. These local integrated networks for older people used the general access point of their Health and social services centers, and in each of these local networks, a common evaluation tool was used to assess the needs of each patient. Services plan would be based on this assessment but a gap can be observed between addressed problems and proposed solutions that are more the services offered by the health and social services centers than by assessed needs. The type of case management varied across networks. For instance, in the highly urban setting, only social workers of the home care team could be case managers while in the urban setting, case managers included different health professionals such as nurses, occupational therapist and social workers. The healthcare information systems were not well implemented. Across the 3

cases studied, few professional teams and healthcare organizations were connected by an information system. Finally, across the 3 cases studied, the primary healthcare practices were not well integrated with public services of the networks. They mostly worked in parallel with respect to the other services of the network.

Conclusion: Ten years after the creation of mandated local integrated networks for older people, several implementation challenges are still observed. The implementation of components of the network show local variations and some key components are poorly developed.

Keywords: integrated care; Quebec