CONFERENCE ABSTRACT

Macro-level institutional entrepreneurship in the implementation of integrated care models for older adults in a top-down and bottom-up context

19th International Conference on Integrated Care, San Sebastian, 01-03 April 2019

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**Introduction:** Integrated community-based primary healthcare models are multi-component organisational models which are embedded in complex multi-level healthcare systems. They are implemented within natural environments marked by complex interactions between actors operating at the macro (policymakers), meso (managers) and micro (providers/users) levels of health systems. Institutional entrepreneurs are actors whose activities shape the way innovations - such as integrated care - are implemented. Furthermore, institutional entrepreneurs operate within top-down (mandated) or bottom-up (enabling) environments, that may influence their activities. Understanding the nature of institutional entrepreneurship in the implementation of integrated care within top-down/bottom-up contexts may inform stakeholders on how to improve the implementation of integrated care. This study aimed at exploring the institutional entrepreneurship of macro-level actors in the implementation of integrated care for older adults in the top-down context of Québec and the bottom-up context of Ontario as perceived by multiple stakeholders.


Qualitative multiple case study consisting of 78 semi-structured interviews of policymakers, managers and providers in Québec and Ontario, and document analysis. The NVivo 11 software was used for a thematic analysis of the qualitative data.

**Results:** Several actors such as policymakers, managers or providers contributed in shaping integrated care in both contexts. With a focus on macro level actors, patient-centered care aimed at improving ageing at home was a subject position both governments of Québec and Ontario articulated in their integration policies. In a top-down manner the government of Québec influenced the implementation of all six dimensions of integration by designing and mandating the implementation of nine major components of integrated care in each of the 94 Local Health Networks of their territory. Conversely, the government of Ontario mainly influenced the systemic and normative dimensions of integration by passing enabling legislation and funding support that enabled the bottom-up development of 82 Health Links with different forms of clinical, professional, organisational, and functional integration.
Discussions: The implementation of integrated care necessitates new practices or the adaptation of existing practices. Both governments articulated patient-centered care and healthy ageing policies but differed in implementation approaches. Québec’s top-down approach resulted in the “same” integrated care model in all Local Health Networks of its territory, while Ontario’s bottom-up approach enabled local communities to develop and shape their integrated care models.

Conclusions: Activities of institutional entrepreneurs in top-down/bottom-up environments highlight the complexity of healthcare systems. Successful implementation of integrated care needs strategies that address various organisational forms.

Lessons learned: Institutional entrepreneurship in various organisational forms can result in different implementation outcomes. This can complicate the implementation of integrated care in real-life contexts.

Limitations: Factors other than top-down/bottom-up organisational forms can influence the activities of institutional entrepreneurs (e.g., funding models) in the implementation of integrated care.

Suggestions for future research: Explore the institutional entrepreneurship of meso and micro level actors in the implementation of integrated care.

Keywords: implementation; integrated care; institutional entrepreneurship