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Key Implications for Decision Makers

Continuity of care depends primarily on the ability of healthcare professionals and managers in a given socio-health region to co-operate with each other. On a small scale, the process for structuring relations between individuals is the path to establishing integrated networks of care. This is particularly clear in the case of pre- and post-natal care.

In this study, the researchers used empirical data to create a tool that will let healthcare managers and professionals assess co-operation among professionals affiliated with various organizations (hospitals, CLSCs, private clinics) on four aspects (services, duplication of services, responsiveness, and health). They can then determine how closely they follow the desired model.

The researchers identified three forms of inter-organizational co-operation: co-operation in action, where there is a great deal of inter-organizational co-operation; co-operation in construction, where relationships are in their early stages; and co-operation in inertia, where there is little co-operation between organizations.

- Regions with the least inter-organizational co-operation clearly show less leadership at the local and central levels. Leaders must give more consideration to opening their organizations to outside professionals, as this is not yet a given in our healthcare system.
- No region has truly overcome the tendency of managers and professionals to focus on the success of their own organization. Settings with the least co-operation are those in which hospitals have not agreed to transfer their responsibilities for post-natal monitoring to primary care.
- It is difficult for professionals from various organizations to get to know each other and develop confidence in each other. Within an organization, the importance of helping professionals get to know each other is recognized, but this is not yet the case for “virtual teams” between institutions.
- Regions with the most inter-organizational co-operation have the best service performance. They deliver the most accessible and most continuous pre- and post-natal services.
- Regions with the most inter-organizational co-operation also have the best response performance. They generally provide the most satisfactory information and the most highly rated services.
- In this study, the level of inter-organizational co-operation does not appear to be linked to the health of the mother and the newborn. Socio-economic level continues to be a major determinant of health.
- Duplication of services is greater in regions with greater co-operation between the hospital and CLSCs. This may be attributable to the difficulty of integrating physicians.

Executive Summary

This study focuses on the organization of healthcare services, specifically on the integration of services among various healthcare organizations. Integration of services is increasingly used by decision makers to design a more efficient method for organizing services, to make them more accessible, more continuous, and also to promote savings in a system with serious financial constraints. Yet there is little evidence available on how to implement integrated services.

For this study, the researchers chose to analyse the integration of services between hospitals and primary care in the field of perinatal care. Since 1995, the length of hospital stays has declined sharply,^{1,2} involving simple care for which there is a consensus on monitoring methods. The initial objective of the study was to identify one or more optimal models of continuity of care as well as the underlying characteristics of these models, and to study the effects of the models.

The research approach used multiple case studies. The researchers analysed models of continuity of perinatal care in four socio-health regions in Quebec. The study involved two components:

- *Qualitative component:* The purpose was to shed light on the articulation of services and all the co-operative links among partners in hospitals, CLSCs, ambulatory departments, and community organizations. To this end, 33 semi-directed interviews were conducted with professionals and managers in various organizations;
- *Investigative component:* This entailed an epidemiological investigation conducted by telephone survey of 1,236 mothers who gave birth in a hospital in one of the four study regions. The survey was done one month after birth. The average response rate was 70.8 percent. The telephone interview gathered data on: 1) services (continuity and accessibility of pre- and post-natal care); 2) duplication of services; 3) responsiveness (information provided to the mother, mother's assessment of services); and 4) health (newborn's health, mother's health, breastfeeding).

Data were analysed in parallel, in two components. For the qualitative component, all interviews were transcribed and three levels of internal analysis for each case strictly applied. The next stage consisted of a cross analysis of four cases based on a narration structure established by the analysis. This analysis highlights very different situations for each region. It was found that the key variable for understanding these situations was the co-operation among partners in the various organizations. Preference was given to this approach to analysis and a co-operation typology was drawn up.

The co-operation typology is based on a model of inter-profession co-operation developed by D'Amour³ and transferred to co-operation among professionals in various organizations. Four factors support this model. The typology identified focuses on three types of co-operation: co-operation in action, where there is a great deal of inter-organizational co-operation; co-operation in construction, where relationships are in their early stages; and co-operation in inertia, where there is little co-operation between organizations.

Two regions have co-operation in action, one has co-operation in construction, and one has co-operation in inertia. In the two regions characterized by co-operation in action, as part of the shift to ambulatory care, responsibility for post-natal monitoring was quickly transferred to CLSCs. These regions also have significant central and emerging leadership in policies and expertise. The quality of leadership ensures that professionals from various institutions centre their services on the needs of clients, not those of professionals or institutions. Beyond the organizations' walls, they have developed relationships based on trust, to support sharing of responsibility for monitoring clients.

In the region that opted for the co-operation in construction type, hospitals continue to conduct many post-natal monitoring activities. The process of constructing co-operation appears to have been slowed by weak central leadership in policies as well as expertise. Many conflicts arose in the sharing of responsibility between hospitals and CLSCs. Despite this, co-operative relationships are slowly but surely being built. Formal forums for concerted action were created for discussing these responsibilities. The partners began from a situation of lack of trust and gradually moved toward a relationship of greater trust in the each others' ability to take on responsibilities.

In the fourth region, which has co-operation in inertia, the hospital and its ambulatory departments take on much of the responsibility for post-natal monitoring. Leadership is confused and ambiguous, so the central authority provides no tangible leadership in the area of perinatal care. Transactions mainly serve the interests of professionals and organizations, rather than clients, and serious conflicts have arisen. There is a lack of trust and each side questions the competence and reliability of its partners. The conflicts effectively cancel out the partners' interests. In this climate there is no improvement in relations. Each new situation becomes an issue for competing negotiations, resulting in much wasted energy.

Analysis of the quantitative data — the effects — reveals that two areas are closely linked to co-operation types: services and responsiveness. The regions that demonstrated co-operation in action show the best performance for services (accessibility and continuity) and responsiveness (information and assessment of services received by mothers). One region performed especially well in speed of post-natal interventions, especially home visits within 24 hours following discharge. This fast intervention did, however, generate a lower degree of responsiveness, since mothers tended to find this intervention time too short.

The regions with co-operation in construction and in inertia are characterized by less accessibility to post-natal visits as well as a higher percentage of mothers who found post-natal services inadequate and the information on breastfeeding contradictory. More mothers also reported that they were not informed at the pre-natal stage of the services they would receive in the post-natal period. In the region with co-operation in inertia, this was compounded by less accessibility to pre-natal courses.

The effect of co-operation types on health and duplication of services is harder to isolate. A region's socio-economic level, especially the extent to which it is under-privileged, has a definite impact on the health of its population. In this study, a mother's mental health and length of breastfeeding are health factors directly linked to the extent to which a region is under-privileged. This is true of one region that has co-operation in action and of the region characterized by co-operation in construction. This situation might indicate a need to allocate some resources to more targeted interventions (such as prevention of psychological distress in mothers).

The rural nature of a region must also be considered when interpreting the results of analysing the effects of co-operation types on health. Geographic dispersal as well as the active role played by a hospital in a region in providing post-natal care may explain the higher rates of readmission of newborns observed in two regions (one with co-operation in action and the region using co-operation in construction).

To varying degrees, we note a duplication of services (in this instance, a home visit and a routine appointment in a doctor's office during the first two weeks following discharge) in all regions, regardless of the type of co-operation used. This duplication varies between 12 and 48 percent. Medical practice guides^{4,5} and ministry guidelines^{6,7} agree that post-natal monitoring in the first 72 hours following discharge from hospital should be provided in the community setting. The role of physicians beyond this 72-hour period is not specifically defined. For follow-up by physicians in private practice, the researchers found large differences in physicians' practices from one region to another. The percentage of mothers reporting a routine visit to their doctor with their infant in the first two weeks following discharge ranged from 18 to 49 percent, depending on the region. These observations appear to indicate that the complementarity of services between the community setting and physicians in private clinics has not truly been the focus of detailed discussions in the regions and that the integration of physicians remains a major issue.