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Primary Care Transformation During a Pandemic: Rapid Reforms Focused on Outreach Approaches and Intersectoral Collaboration to Better Serve Vulnerable Populations

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Abstract

This article examines how existing primary care services were transformed in Québec during COVID-19 to better serve the most vulnerable individuals for whom inequities and access difficulties increased during the pandemic. In the context of a research project, six particularly promising practices to respond to these challenges were identified within one *Centre intégré universitaire de santé et de services sociaux* (CIUSSS). Using van Gestel et al.'s (2018) framework, which focuses on timing, ideas and institutional contexts, these practices are analyzed as rapid reforms, that is, policy responses or innovations that are initiated at an unusual pace in high pressure contexts, such as the COVID-19 pandemic, that provide an unprecedented window of opportunity to transform primary care services. The extreme pressure exerted on politicians and public decision-makers to act quickly created a context, characterized in certain circumstances by a decentralization of decision-making in the health system and greater agency by frontline actors, favouring bottom-up innovations. Despite the emergence of various rapid reforms, certain longer-term questions arise regarding their potential for sustainability, because their implementation has not been based on an in-depth redefinition of institutional structures and logics, which rests on the long-term adoption of new norms and values.

Cet article examine comment les services de première ligne ont été transformés au Québec pendant la COVID-19 afin de mieux desservir les clientèles vulnérables, pour lesquels les inégalités et les difficultés d'accès se sont accrues pendant la pandémie. Dans le cadre d'un projet de recherche, six pratiques particulièrement prometteuses en réponse à ces enjeux ont été identifiées au sein d'un Centre intégré universitaire de santé et de services sociaux (CIUSSS). En utilisant le cadre de van Gestel et al. (2018), qui s'attarde au timing, aux idées et aux contextes institutionnels, ces pratiques sont analysées comme des réformes rapides, c'est-à-dire des politiques ou des innovations initiées à un rythme inhabituel dans un contexte de fortes pressions, tel que la pandémie de la COVID-19, et offrant une fenêtre d'opportunité sans précédent pour transformer les services de première ligne. La pression extrême exercée sur les politiciens et les décideurs publics pour qu'ils agissent rapidement a créé un contexte, caractérisé dans certaines circonstances par une décentralisation de la prise de décision dans le système de santé et une plus grande capacité d'action des acteurs sur le terrain, favorisant les innovations « du bas vers le haut » (bottom-up). *Malgré l'émergence de ces réformes rapides, certaines questions à plus long terme se posent quant à leur potentiel de pérennisation, car leur mise en œuvre n'a pas été fondée sur une redéfinition en profondeur des structures et logiques institutionnelles, qui repose sur l'adoption à plus long terme de nouvelles normes et valeurs.*

Key Messages

- The COVID-19 pandemic created a window of opportunity for greater policy recognition of the importance of primary care services.
- The need to react quickly and to develop new ways of organizing primary care services to reach more vulnerable individuals fostered a greater tolerance for risk, encouraging experimentation, innovation and allowing some non-mainstream practices to gain legitimacy in the context of the pandemic.
- The rapid reforms pertaining to mental health and families in vulnerable situations were situated within a more sustained and structured intersectoral collaboration based on the valuing and complementarity of expertise of various sectors.
- Vigilance is needed to avoid a return to previous ways of doing things, particularly with respect to collaboration, leadership, and mobilization of frontline workers.

Messages-clés

- *La pandémie de la COVID-19 a créé une fenêtre d'opportunité pour une plus grande reconnaissance politique de l'importance des services de première ligne.*
- *La nécessité de réagir rapidement et de développer de nouvelles façons d'organiser les services de première ligne pour rejoindre les clientèles plus vulnérables a favorisé une plus grande tolérance au risque, encourageant l'expérimentation et l'innovation et permettant à certaines pratiques non conventionnelles de gagner en légitimité dans le contexte de la pandémie.*
- *Les réformes rapides concernant la santé mentale et les familles en situation de vulnérabilité se sont inscrites dans le cadre d'une collaboration intersectorielle plus soutenue et structurée, fondée sur la valorisation et la complémentarité de l'expertise des différents secteurs.*
- *La vigilance s'impose pour éviter un retour aux anciennes façons de faire, notamment en ce qui concerne la collaboration, le leadership et la mobilisation des intervenants de première ligne.*

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1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

This article examines how primary care services[1] were transformed in Québec (Canada) during the COVID-19 pandemic to better serve the most vulnerable members of the population—in particular, those individuals with mental health challenges and families in vulnerable situations who have been disproportionately affected by the pandemic. Primary care services refer to those offered as close as possible to the population of a territory (MSSS 2004), and that privilege interprofessional approaches centred on the person and strong intersectoral partnerships (Haggerty et al. 2007; INESSS 2019). They are recognized as being the foundation of an effective and efficient health system (Breton et al. 2017; WHO 2022). However, despite numerous reports emphasizing the importance of primary care (Starfield, Shi, Macinko 2005; WHO 2008), the health and social services system in Québec, like many jurisdictions, has historically favoured a hospital-centrism characterized by a concentration of resources in acute care facilities (Desrosiers 1999; Hébert, Sully, Nguyen 2017; Québec Ombudsman 2021). The pandemic highlighted the importance of primary care services, capable of intervening as near as possible to the population and adapting quickly to the social and health challenges raised by the COVID-19 crisis (Rochon 2020). To this end, different practices were deployed in the *Centres intégrés de santé et de services sociaux* (CISSS) and the *Centres intégrés universitaires de santé et de services sociaux* (CIUSSS) across the province to respond to the recognized needs of certain vulnerable populations. The CISSS and CIUSSS are Québec's merged health and social services organizations that were established in 2015. One of their mandates is to provide primary care to the population in their respective territories. A range of services are offered, including community, primary care, rehabilitation, and specialized care. In this article, we report on research about innovative practices in primary care that target mental health services and support for vulnerable families within the context of the pandemic in one CIUSSS, namely the *CIUSSS de la Capitale-Nationale* (CIUSSS-CN).[2] The study sought to identify the factors that fostered the emergence and sustainability of primary care innovations for these vulnerable populations.

Vulnerability refers to the state of populations or individuals in "... a disadvantaged position in social hierarchies defined by wealth, power, and/or prestige, which place them at risk for poor health" (Ashkin 2018, 331). Poor health is the result of precarious living and working conditions and the adoption of risk behaviours, but is also due to limited access to health resources and services (INESSS 2019). Even before the pandemic, people

[1] In this article, we use *primary care* because the overall coordination of the services that we describe is carried out within the health care system. However, given the involvement of a broader range of stakeholders in the innovations, we recognize that *primary health care* could also be used.

[2] CIUSSS-CN serves both urban and rural areas. It serves the needs of more than 766,579 citizens residing in a territory of 18,643 km^2. It is responsible for more than 200 facilities, including hospitals, local community service centres (CLSCs), long-term care centres (CHSLDs), rehabilitation centres, etc.

in vulnerable situations, despite their greater needs, had more difficulty accessing primary care services (Waisel 2013; Loignon et al. 2015; Corscadden et al. 2018). Recent studies show that barriers and inequities in access to care and services have increased since the outbreak of the pandemic and that in several countries, including Canada, the provision of services has not been well adapted to these individuals' specific needs (Bambra et al. 2020; Haggerty et al. 2020; Torous and Keshavan 2020; Spooner et al. 2021). In addition, the social and economic problems caused by the pandemic led to a significant increase in the number of individuals in vulnerable situations, which in turn placed increased pressure on the health system (Ahmed et al. 2020; Bélair-Cirino 2020; Nicola et al. 2020; CMA 2021). Furthermore, individuals in vulnerable situations are at greater risk of both experiencing the psychosocial consequences of the pandemic and contracting COVID-19 (NIHCM 2020; Moghanibashi-Mansourieh 2021; Santé Montréal 2022). It is therefore important to document how primary care services changed due to the pandemic to enable vulnerable individuals to have more equitable access to services that are better adapted to their needs and the complexity of their situation (Ouimet et al. 2015; Ford-Gilboe et al. 2018; Farley et al. 2020; OECD 2021).

We identify six particularly promising practices related to the provision of primary care services (see Table 1) in four sectors serving certain vulnerable populations from a previous scan of innovations.[3] Even though these six practices were selected for specific analysis, this scan revealed a much higher number of service adaptations or innovations targeting these individuals. Most of the practices identified were already being tested on a small scale within the CIUSSS-CN or were at the project stage before the pandemic; few of the practices identified were completely new. Data collection was conducted in the spring of 2021, one year after the start of the pandemic. Except for one of the initiatives (*Integrated services for victims of abuse*), about which considerable preparatory work with several intersectoral stakeholders[4] was taking place, the practices had all been in place for more than eight months. In this article, these practices are analysed as *rapid* reforms, that is, policy responses or innovations that are initiated at an unusual pace in high pressure contexts. Based on the criteria used to select the practices, Table 1 provides a brief description of the innovative practices, the type of collaboration that underlies the deployment of each practice, and the leadership styles that were favoured. Our analysis revealed the importance of a fourth emerging dimension that refers to the agency of certain individuals who played a particularly important role, known as *boundary people*, in the implementation of the practices. These are individuals who have a hybrid profile of training and experience that

[3]The project included two phases. First, we met with department leaders to identify innovative practices in the areas of primary care that had been introduced to address the needs of individuals with mental health challenges or families in vulnerable situations during the pandemic. Second, using explicit criteria (new practice or practice that has been adapted and scaled up, new mode of collaboration, change in leadership), we selected six promising practices that were considered the "cases" under investigation.

[4]The term intersectoral refers to the links between CIUSSS-CN and stakeholders outside the health system like the municipalities, the police, the schools, etc.

enables them to navigate between several worlds, to negotiate between sometimes divergent interests, and to find ways of moving between the different institutional logics in order to advance the projects (Stern and Green 2005). This element is also captured in Table 1.

Table 1: Overview of practices

Practices	**Interprofessional/ Intersectoral collaborations**	**Leadership**	**Boundary people**
Optimizing the role of paramedics: The paramedic role was expanded to create alternative trajectories not requiring emergency room (ER) visits. This role, synchronized with nurse practitioners' (NPs) evaluation function, targeted a broader population, including people with mental health challenges and vulnerable families.	This practice includes collaboration with various partners: Family Medicine Group (GMF), community organizations (mental health, food bank, community nursing, etc.).	Leadership is provided by frontline paramedics who promote the project to their colleagues. Managers and coordinators also provide strong leadership for its sustainability in the CIUSSS-CN.	Paramedic: training as a paramedic and in nursing. NPs: favoured NPs with ER experience. Manager: frontline experience as a paramedic.
Convalescent Centre (CDC) and establishment of a Homeless Liaison team: A convalescent centre and homeless liaison team were created to provide safe housing and interventions for individuals in a precarious social situation, many of whom are struggling with mental health challenges. To ensure public safety, this practice relied on an unprecedented coordination and collaboration between several stakeholders (see next column) in the region.	Located in a shared space, a multidisciplinary team (social worker, nurses, special education technician, occupational therapists, etc.) collaborates with community organizations working with mental health and homeless populations, and the police department.	Avoiding *top-down* approaches between CIUSSS-CN and the community network by shared leadership.	Some professionals and managers can intervene within the institutional framework of the CIUSSS-CN services and within a harm reduction philosophy that is coherent with community perspectives.
Outreach clinician deployment: Outreach clinicians were deployed to reach vulnerable populations who did not typically seek services (including vulnerable families and individuals with mental health challenges) and who became even more vulnerable during the pandemic. This approach, including the services provided, was based on community empowerment, and significantly differed from previous approaches.	Partnerships between CIUSSS-CN (social worker, community organiser) and the local community network.	Shared leadership between the project coordinator, the manager, and the community organisers, who act as a hub between the local services network and the outreach workers.	The initiator of the approach can translate well this new mode of intervention having been a former clinician.

Assignment of school liaison personnel in elementary and secondary schools: This practice was implemented to intervene quickly with families in difficulty by developing a service-referral pathway to the CIUSSS-CN, permitting some families to avoid recourse to the youth protection service and better target the right service for them. The novelty lies in the fact that the liaison personnel can now refer directly to the CIUSSS-CN based on a decision support tool.	Frequent collaboration between focal points (key frontline service providers), school responders (special education technicians, teachers) and project managers to refer students to the appropriate youth services.	Leadership is shared among school-based practitioners, who have an important role to play with their colleagues in promoting awareness and value of the practice, and the project leader and the manager.	The project manager is central to the project and serves as a liaison between the various partners.
Revision of the crisis intervention program and addition of an immediate response service: This innovation permitted the provision of immediate services to minors (0-17 years) with mental health challenges or in a psychosocial crisis to avoid systematic admission to child psychiatric emergency services. The objective was to avoid inappropriate ER visits and deploy services directly in the community.	Close collaboration between social workers, child psychiatric ER, police department and youth protection allows for rapid intervention with families.	The manager adopted a participatory leadership approach with his team to identify solutions and keep his team engaged.	Two coordinators involved in the collaboration have both management and clinical experience, which helped the frontline workers to adapt to their new intervention context.
Integrated services for victims of abuse (SIVA): Faced by a considerable increase in domestic and sexual violence during the pandemic, a significant reorganization of services, including a network of partners with psychosocial, medical, law enforcement, legal and community expertise, was carried out to better respond.	Located in a shared space. Intersectoral multidisciplinary team with police, medical, legal, psychosocial and socio-judicial expertise. Twenty-nine stakeholders are actively involved in the construction of this project.	Shared and alternating leadership between the city, the CIUSSS-CN and involving the active participation of other stakeholders.	One person on the coordinating committee has a hybrid expertise: she previously worked in a community organization for abused women and subsequently held several positions within the CIUSSS-CN.

2 HISTORY AND CONTEXT

Although the importance of primary care has long been recognized in Québec (Pineault et al. 2008; Wankah et al. 2022), efforts to implement reforms have met with variable success. However, in recent years, several factors created the impetus for the emergence of the rapid reforms discussed in this article. In 2015, a major restructuring of the health care system in Québec was implemented (National Assembly of Québec 2015). This reform included a consolidation of health jurisdictions, specifically the creation of the CISSS and CIUSSS within the 18 provincial health/social services regions. The CISSS/CIUSSS have a population-based responsibility, that is, they are obliged to reach out to the people residing in their territory and not only offer services to those who request them. They are expected to contribute to improving the overall health of the population in their terri-

tory (CIUSSS-CN 2022). Despite this mandate, various factors (e.g., budgetary constraints, limited intersectoral collaboration) limited the progress made (Hébert, Sully, Nguyen 2017).

The pandemic served, via an alignment of several factors (e.g., the urgency to act, the unpredictability of the evolution of the situation, political issues, the particularly important consequences on certain populations), as an important catalyst for the improvement of services (Breton et al. 2022). The gaps in services for some populations in vulnerable situations, such as individuals with mental health difficulties, were exposed (Murphy et al. 2021). These gaps were exacerbated, or highlighted (e.g., victims of domestic abuse), by the public health restrictions imposed (Weikle 2020). As noted by Québec's Ministry and Health and Social Services [Ministère de la Santé et des Services sociaux (MSSS)] during the pandemic, "...the current context calls for a re-evaluation of frontline activities, particularly with a view to protecting the most vulnerable and freeing up additional capacity" (translation: MSSS 2020a).

Health and social services were forced to rapidly adapt to the public health restrictions. Subsequently, a combination of the need for rapid regional responses and a significant injection of resources by the government appeared to produce the conditions for implementing creative solutions to address the gaps. Various initiatives and innovations emerged that appeared likely to significantly and rapidly transform the organization of primary care services in the short and long term. Furthermore, the challenges faced required more sustained intersectoral collaboration between the various stakeholders in the CISSS/CIUSSS territories (Denis et al. 2020). This requirement seemed particularly applicable to vulnerable individuals, the complexity of their situation requiring coordinated interventions between multiple health and social services professionals. To understand the rapid reforms undertaken and their conditions of emergence and implementation, three dimensions of the policy-making process (timing, ideas and institutions) will be analysed. A final section will deal with the implementation phase of the policy cycle.

3 THE POLICY-MAKING PROCESS

The analytical framework used to examine the policy-making process in this article is that developed by van Gestel et al. (2018), in which the three predominant models in public sector reform were integrated (*Advocacy Coalition Framework, Institutional Theory Approaches, Multiple Streams Framework*). This framework permits a more global and rich understanding of policy processes by paying attention to the central driving role of *timing, ideas,* and *institutions*. The three underlying models appear to be complementary and interdependent in that they shed light on different angles of policy processes at different levels (micro, meso, macro) and temporalities (van Gestel et al. 2018). This analytical framework is particularly useful for analyzing primary care changes during the pandemic. With respect to timing, it facilitates the conceptualisation of the pandemic as an event that triggered the opening of a policy window that connects the social problems exacerbated by

this crisis, the solutions advocated and the political imperatives on a government that must demonstrate its ability to act (Kingdon 1995). It allows an analysis of the way in which certain *ideas* and *interests*, supported by a coalition of stakeholders, have come to impose themselves (Sabatier and Weible 2014) and gain legitimacy given constrained institutional contexts (Suchman 1995; Scott 2014). The framework also draws attention to the central role played by certain individuals who are particularly adept at using this window of opportunity to promote changes in the desired direction. As well, it focuses on the resources needed to accomplish these rapid reforms, be they human, financial, or technological.

3.1 Timing: a window of opportunity for recognizing the importance of primary care

The pandemic provided an unprecedented window of opportunity to highlight the central role of primary care for those individuals most affected by this crisis. As the pandemic continued and lockdowns followed one after another, many stakeholders (e.g., managers, practitioners, researchers) expressed serious concerns about vulnerable individuals, particularly those with mental health challenges, those experiencing homelessness, and families in vulnerable situations (Leblanc, Bertrand, Loignon 2020; Wathen 2020).

The rise of domestic violence in Québec during the pandemic—as well as its most extreme expression, feminicides—confirmed these concerns (Bogart 2020; CSF 2021; Venkatesh et al. 2021). So did the significant increase in requests for mental health services and the calls for help from community organizations responding to homelessness, which were overwhelmed by the measures instituted and the lack of resources (Landry 2021; Morin-Martel 2021). Given the scale of the challenges, and to reassure the public, the government committed significant funding for primary care, making this sector a key actor during the crisis. Thus, the pandemic context permitted a convergence of ideas and interests of a coalition of influential stakeholders (politicians, public decision-makers, experts, professional associations) who promoted greater recognition of primary care (Couturier and Hudon 2020; Denis, Côté, Régis 2020). This recognition was translated into a political discourse affirming a commitment to support the most vulnerable in society through financial investment to increase frontline capacity. Numerous investments were made in Québec by provincial and federal governments throughout the early months of the pandemic to, among other objectives, increase mental health services for youth (MSSS 2020b; 2020c), support community organizations (MSSS 2020d), assist vulnerable and/or homeless individuals (MSSS 2020e; 2021), and increase access to psychosocial and mental health services (MSSS 2020f; 2020g).[5] In the longer term, this commitment to strengthen health care services is embodied in a two-part provincial plan, *Restore the health care system* ($5.2B investments by

[5]Details of the various investments made by the Government of Québec, and specifically those in primary care (e.g., $526M to improve access to frontline services) can be found in section B.41 "Strengthening health care and services" of Québec's Budget Plan 2021-2022 (Gouvernement du Québec 2021).

2026-2027) and *Enhance health care and services for the public* ($3.7B by 2026-2027)—the latter mainly covering primary care services.[6]

In sum, the pandemic constituted an unprecedented window of opportunity in which there was a general recognition of the importance of primary care associated with pressure on the government to provide this sector with additional resources. In addition, primary care organizations recognized the importance of mobilizing to adapt quickly and innovate in a context of significant financial restrictions, particularly at the beginning of the pandemic.

3.2 Spaces for experimentation and innovation: articulating ideas and institutional legitimacy

At the local level, within the CIUSSS-CN, several primary care sectors were active in developing or adapting their services to reach the most at-risk individuals in their territory during the pandemic. The pandemic served as a catalyst for the wider deployment of practices, some of these being more non-mainstream, which were struggling to be fully deployed within the organization and to acquire legitimacy before the pandemic. As rapid reforms, these practices did not emerge entirely during the pandemic but were, rather, brought up to speed by COVID-19 and adapted for different population groups. For example, the outreach approach had been tested well before in a pilot project targeting refugee populations; however, it had remained limited to this group despite the efforts of certain managers, project leaders and researchers who had championed this mode of intervention. The project regarding the optimization of the role of paramedics faced major constraints in its implementation, particularly in relation to the limits imposed by the law on pre-hospital services and the questions regarding the professionalization of this group of practitioners. The partnership links between community organizations and mental health (DSMD) and family and sexual violence (DSM) programs of the CIUSSS-CN were historically characterized by ongoing tensions due to being undersubsidized or having divergent intervention approaches. These tensions left many members of the community organizations feeling overlooked by the CIUSSS-CN in several frontline services (e.g., shelters, soup kitchens, relocation programs for homeless individuals, sexual assault help centers (CALAC), housing for sexual assault victims).

In different ways, depending on the specific practice, the pandemic context permitted the removal of certain barriers, and experimentation with new ways of providing care and collaborating with different stakeholders within the CIUSSS-CN and more generally in the territory. For example, changes to the law have allowed paramedics to streamline their

[6]Further details can be found in section C of Québec's Budget Plan 2022-2023 (Gouvernement du Québec 2022), or on pages 43-44 of the Canadian Medical Association Report *Measures to Address Health System Challenges: Review of Canadian, Provincial and Territorial 2022 Budgets*(CMA 2022) for a review. Simultaneously, the emergency context and the obligation to move quickly favoured the development of several local bottom-up frontline initiatives in which middle managers and service providers were mobilized to participate actively in adapting the services to the needs of the population.

professional role to avoid routinely taking individuals to the emergency room. The establishment of the convalescent centre for homeless individuals was based on a more equal collaboration between the CIUSSS-CN and the community organizations involved. The need to react quickly and to find solutions to new problems created a context favourable to taking risks and experimenting with new ways of doing things. Several processes were made more flexible, particularly regarding the assistance offered by the sector managers supporting the change, for example, information technology support, human resources and facilities management. The union demonstrated greater flexibility in relation to specific collective agreements to enable the frontline service providers to adapt their service offer more quickly, as in the case of the revision of the crisis intervention program that required a special agreement with the union for the revision of work schedules. As well, workers took on additional tasks to ensure that innovative practices could be initiated. For example, advanced NPs were asked to add an on-call weekend shift in the optimization of the paramedic role practice, and health professionals were asked to work night shifts at the convalescence center in order for these practices to be implemented.

The specific key stakeholders involved in these rapid reforms differed from practice to practice and were situated at several levels of the system. Although the MSSS played an important role in the transformation of the frontline services during the pandemic by injecting additional funds into targeted areas, prior to this, sector managers had begun to adapt their services by improving their program or by proposing certain practices specifically adapted to the pandemic context.

Driven by the need to react quickly, the frontline services were mobilized in an important and unusual way, as much by middle managers as by direct service providers or certain project managers, who were often required to play an expanded role during this period. As well, certain actors outside the CIUSSS-CN (e.g., municipal government, police, primary and secondary schools, community organizations) became central in the deployment of these practices through the development of more sustained and formalized collaborations. Faced with the need to make rapid changes, Québec's highly centralized health and social services system came to rely more heavily on local initiatives, leaving more room for manoeuvre for local organizational decision-makers in identifying solutions adapted to the reality of their territory. Areas of experimentation emerged, giving rise to innovative projects mobilizing several stakeholders in the field and carried out in most cases within a logic of co-construction of services. We are referring here to the process by which different actors engage in a transformation of their initial respective perspectives until they agree on solutions that they do not perceive to be incompatible (Foudriat 2016).

In short, the pandemic context created a space conducive to experimenting with new ways of doing things by focusing on the mobilization of frontline service providers, the optimization of managerial and professional roles, supporting more sustained intersectoral collaboration, and exercising greater tolerance for risk-taking. These new ways of intervening, collaborating and mobilizing were deployed in a context that made it possible to legitimize new values and institutional logics on which the implementation of these rapid

reforms was based.

4 IMPLEMENTATION OF RAPID REFORMS TO BETTER SERVE POPULATIONS IN VULNERABLE SITUATIONS

Although the six practices identified differ in several aspects, they have certain similarities. Our focus in this article is on the cross-cutting elements that have favoured or limited the implementation of these rapid reforms. Each of the six practices endeavoured to develop a service aimed at working more closely with specific populations by intervening directly in their environments. The practices were based on the introduction of new structures such as intersectoral committees or the implementation of new professional roles that favoured the deployment and constant adjustment of practices according to the changing realities in the field. They were able to rely on practices already existing within the CIUSSS-CN that had a cross-cutting function (e.g., 811 non-urgent health issues call line, service access points), which favoured a greater capacity for networking between the sector managers and with local partners. These practices also required additional investment of human and financial resources. The offloading of certain activities made it possible to concentrate human resources in priority areas. The urgent situation and the feeling of having to join forces to limit the virus' impact encouraged a high level of commitment from staff, particularly in the first waves of the pandemic, despite the considerable difficulties, discomforts and concerns experienced.

These practices are characterized by more diversified and sustained collaboration between different partners in the territory. Paramedics were brought in to collaborate with the family medicine group and with some community organizations (e.g., mental health, food bank, community nursing). The empowerment of communities was based on a close collaboration between CIUSSS-CN (social worker, community organizer) and the broader local community network. They also stand out with respect to collaboration methods, where more egalitarian relations were favoured between CIUSSS-CN actors and local partners, notably through a greater appreciation of each other's expertise and the efforts to optimize their complementarity. Despite these positive elements, ethical issues related to confidentiality have contributed to limiting more formal and structured collaborations.

The way in which leadership was exercised in the implementation of these rapid reforms is another element that characterizes these innovative practices. For example, the SIVA practice was based on shared and alternating leadership between the city, the CIUSSS-CN and involved the active participation of many stakeholders. The assignment of school liaison personnel (professionals attached to the CIUSSS-CN Youth Directorate) in elementary and secondary schools relied on shared leadership among school-based personnel (e.g., special educators), who had an important role to play with their colleagues in promoting awareness and value of the practice, and the project leader and the manager in the CIUSSS-CN.

The unprecedented nature of the situation and the lack of certainty about the solutions to be implemented created the conditions for a more shared leadership between different actors within the organization and with local partners. Managers, practitioners and project leaders from the CIUSSS-CN and other organizations played a leadership role in the implementation of these practices at different times, sometimes alternating between them. The results show that in several cases these stakeholders' roles were expanded and optimized. In addition, the innovative practices were developed with the support of certain key individuals, the boundary people (Stern and Green 2005), who demonstrated strong leadership in the implementation of these different practices, sometimes in a formal leadership role (e.g., crisis intervention, CDC) or sometimes less formally (e.g., paramedics, assignment of school liaisons in schools). As mentioned, innovative practices rely heavily on intersectoral collaboration where boundary workers act as intermediaries between the various organizations involved. Their intricate knowledge of multiple organizations allows them to understand the perspectives of these different organizations, and sometimes the divergent interests between them. This knowledge may include the particular culture of each organization (Williams 2002), but also the power dynamic that inter-organization partnerships may generate. In this way, boundary people demonstrate both leadership and the ability to find ways of moving between the different institutional logics to advance the projects.

Nevertheless, the state of urgency and haste in which the changes had to be implemented caused some difficulties. Managers did not have time to prepare the terrain and to transmit the vision of the changes in a structured manner. Most of the time, this communication took place during implementation and a great deal of work was needed to reiterate, on an ongoing basis, the meaning of the practices in order to maintain the mobilization of the teams. In addition, the speed of the changes generated significant pressure on managers and service providers who had to adapt their practices without always having the time to integrate and master the new ways of doing things, often without appropriate management tools. The results show that this pressure has had varying effects on workers and managers, some being more affected than others by the difficulties experienced. While support for teams was generally put in place to facilitate the adoption of changes, the nature of this support tended to be identified in reaction to needs that emerged during the implementation of the projects rather than proactively planned.

In summary, the extreme pressure exerted on politicians and public decision-makers to act quickly created a particular context, characterized in certain circumstances by a decentralization of decision-making in the health system and greater agency on the part of frontline actors, favouring bottom-up innovations. The crisis was a policy window that foregrounded primary care and service provision for vulnerable families and individuals. It also allowed some innovative ideas (outreach practices, intersectoral collaboration, leadership style) to be adopted because they were better adapted to meet the needs of some of the most vulnerable populations. However, despite the emergence of the important initiatives, several longer-term questions arise with respect to their potential for sustainability, since the implementation of these rapid reforms has not been based, at least initially, on a for-

mal redefinition of institutional structures and logics leading to the adoption of new norms and values. The implementation of rapid reforms has been possible thanks to a significant and sustained commitment from professionals and managers in the field. The facilitators and barriers to sustainability of frontline practices requires careful reflection regarding the conditions for mobilization and engagement.

We must acknowledge certain potential limitations in our analysis. Notwithstanding the large catchment area, population served, and extensive range of services provided by the CIUSSS-CN, we cannot presume that the organizational configuration and links with other stakeholders are necessary generalizable to other CISSS/CIUSSS. Despite the criteria that we used to select the six innovative practices to focus on, other researchers might have arrived at different choices given the range of practices that were initially identified. In addition, it is difficult to estimate the sustainability of the initiatives that we studied given the relatively short period of time of our investigation.

The issues involved in implementing these rapid reforms are presented in the SWOT Analysis in Table 2.

5 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 2: SWOT Analysis

Strengths	Weaknesses
• Since the pandemic, the health and social services system has relied more heavily on local and bottom-up initiatives. • Faced with the urgency, frontline service providers' expertise was strongly mobilized to identify innovative practices and the role of boundary people has been central in navigating the different institutional logics. • The rapid reforms were based on a more sustained and structured intersectoral collaboration based on the valuing of expertise of various sectors and their complementarity.	• The rapid speed of implementation of the practices made it difficult to provide adequate support to service providers and to sufficiently convey the vision of change, particularly at the onset of the pandemic. • Some ethical issues have limited intersectoral action between health and other sectors. • The adaptation of services over a very short period has put significant pressure on managers and service providers, with varying effects on their capacity to remain mobilized.
Opportunities	**Threats**
• The pandemic has created a window of opportunity for greater recognition of the importance of primary care and community-based intervention. • The need to react quickly and to develop new ways of doing things to reach more vulnerable individuals has fostered a greater tolerance for risk, encouraging experimentation, innovation and allowing some marginal ideas to become particularly adapted in the context of the pandemic. • The context has fostered an expansion and optimization of roles as well as more shared leadership.	• The sustainability of rapid reforms depends on maintaining adequate funding for primary care and a balance between top-down orientations and bottom-up initiatives. • Incentives created during the pandemic (e.g., financial, professional) are slowly being abandoned, thus vigilance is needed to avoid returning to previous ways of doing things, particularly with respect to collaboration, leadership, and mobilization of frontline service providers. • Workforce shortages regarding occupational health, and engagement may limit the ability of primary care organizations to innovate.

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