Highlights from the descriptive report of the organizational survey in the Montérégie region

Audrey Couture, Raynald Pineault, Alexandre Prud'homme, Sylvie Provost, Roxane Borgès Da Silva, Jean-Frédéric Levesque, Pierre Tousignant

In 2005, the Population Health and Health Services team, a joint team from Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal and Institut national de santé publique du Québec, conducted a study in the two most populated regions of Québec (Montréal and Montérégie). The goal of the study was to evaluate the association between primary care organizational models used at that time and the population's care experiences. A second study was undertaken in 2010 to understand the evolution of primary care organizational models and their performance during the healthcare reform process, and to evaluate associated organizational and contextual factors.

The study consisted of three interrelated and hierarchically nested surveys:

- A population survey of adults randomly selected among the population of both regions to assess patient affiliation with primary care organizations, use of services, various attributes of patient care experience, preventive care received, and perception of unmet needs.
- A survey of primary care organizations to evaluate aspects related to organizational vision and structure, resources and clinical practice characteristics, as well as primary care service reorganization.
- A third survey of key informants from Health and Social Services Centres to assess the organizational contexts within which the different organizational models evolve.

Introduction

In the early 2000s, two major reforms were undertaken in Québec. The goal for the first reform was to implement Family Medicine Groups (FMG). For the second, the objective was to create Health and Social Services Centres (CSSS), whose main responsibility was to develop Local Services Networks (RLS). This required CSSS to support the development of FMG.

This document aims to describe the reform-related changes observed between 2005 and 2010 in primary care organizations in Montérégie. Findings are reported first on the change in number of medical clinics* between 2005 to 2010, and then on the analysis of the modifications in the characteristics of these clinics during this period. The findings are presented for the region as a whole and for each CSSS territory in the region.

To measure organizational change, we calculated an index of conformity to an ideal type (ICIT). Construction of the ideal type was based on the literature concerning the most promising primary care organizational models. We chose 26 indicators distributed according to the dimensions "vision", "resources", "structure" and "practices". The table on the next page presents the four dimensions that were used to construct the ICIT, along with their definitions and the number of variables included. The higher the ICIT score (maximum: 100), the closer a medical clinic is to the ideal type. We set at 2.0 the value for significant differences between ICIT scores for 2005 and 2010. Between +2.0 and -2.0 we consider that the situation has remained stable. Data findings for this second part were weighted to take into account clinic size, measured by the number of full time equivalent physicians in the clinic. Data weighting allows for more accurate picture of services offered in CSSS territories.

Other methodological details can be found in a methodological report (Prud'homme et al., 2012). Detailed results are presented in a descriptive report, which is available on the Web sites of Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal and of Institut national de santé publique du Québec (addresses at the end of the document).

---

* In this summary, the term "medical clinic" is used instead of "primary care organization".

Changes in number of medical clinics from 2005 to 2010

- The number of primary care clinics only declined by 4 between 2005 and 2010, going from 225 to 221.
- CSSS Pierre-Boucher was the one most affected by losses, even when additions are taken into account (- 5).
- The main reasons for closures were, in order, merges with other medical clinics (55.2%), and retirement or death of physicians (41.4%).
- Most clinics that closed were solo practices (72.4%) and, to a lesser degree, group clinics (not FMG) (17.2%).
- We note that from 2005 to 2010, there was a relatively significant increase in FMG-type clinics (from 15.6% to 25.3%), and the creation of network clinics (NC) (from 0% to 0.5%) and FMG-NC (0% to 1.4%); consequently, there was a relative decrease in the other types of clinics.
- FMG and NC implementation was unequal in the region. FMG implementation progressed between 2005 and 2010, especially in CSSS Haut-Richelieu–Rouville (from 0% to 31.0%) and Richelieu–Yamaska (from 6.5% to 36.4%). NC implementation only got under way in CSSS Champlain–Charles-Le Moyne (2.8%). In 2010, for the region as a whole, these clinics made up 27.2% of all clinics.

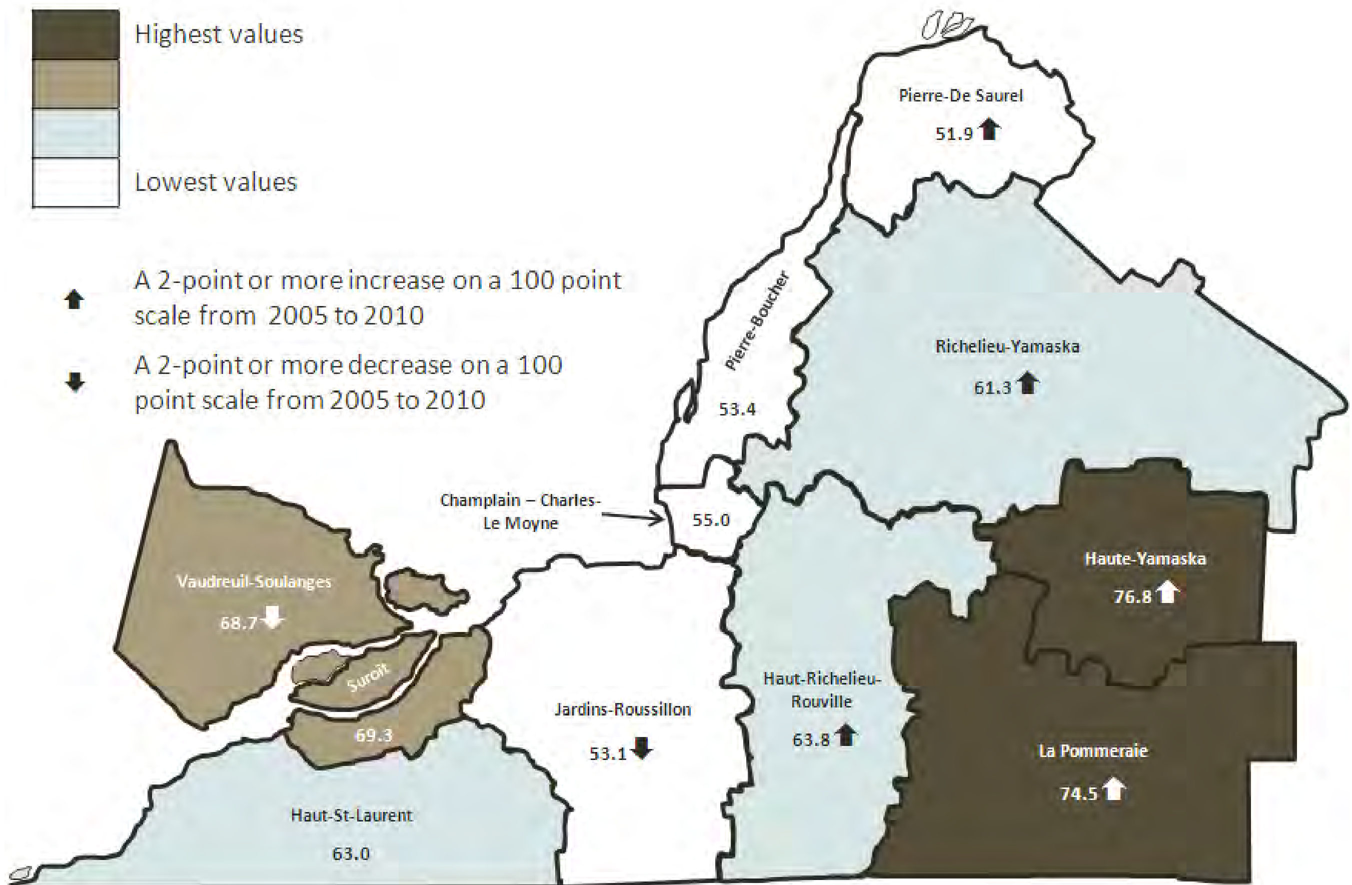
Dimensions of the index of conformity to an ideal type (ICIT)

Dimension	Definition	Number of variables
Vision	Goals, values and orientations shared by clinic members	4
Resources	Quantity and type of resources available in the clinic	7
Structure	Rules of governance, agreements and procedures that guide clinic activities	6
Practices	Administrative and professional procedures put in place to support clinical practices	9

Analysis of changes in organizational characteristics of clinics between 2005 and 2010

- Five of the CSSS territories in Montérégie saw their overall ICIT scores increase between 2005 and 2010, four remained stable and two showed decreases: de Vaudreuil–Soulanges (-3.8) and Jardins-Roussillon (-2.1). The strongest increases were for CSSS Haut-Richelieu–Rouville (+12.2) and Richelieu–Yamaska (+6.3). We also note a wide variation in ICIT scores for 2010 among CSSS territories; they ranged from 53.1 for CSSS Jardins-Roussillon to 76.8 for CSSS de la Haute-Yamaska (Figure shown on the next page).
- For the region, we note that the increase in ICIT scores between 2005 and 2010 concern mostly structures (+5.2) and resources (+3.4). The ICIT score for vision remained stable while that for practices rose slightly (+2.7).
- The most significant changes are related to the dimension “structure”. We note an increase in ICIT scores for six CSSS territories. The strongest increases were for CSSS Pierre-De Saurel (+21.5) and Haut-Richelieu–Rouville (+21.4). There were decreases for four CSSS territories, the most significant one for CSSS du Suroît (-10.2), and one CSSS was stable. In 2010, ICIT scores for this dimension varied significantly among CSSS territories, ranging from 35.8 for CSSS Jardins-Roussillon to 84.0 for CSSS La Pommeraie.
- We also observed increases for four CSSS territories regarding the “resources” dimension, although these are less important than for “structure”. CSSS Haut-Richelieu–Rouville showed the most significant rise in ICIT score (+13.2). Scores remained stable for four CSSS territories and dropped for three, with CSSS de Vaudreuil–Soulanges showing the most significant decrease (-7.2). In 2010, ICIT scores for resources varied significantly among CSSS territories, although less so than for structure, ranging from 56.2 for CSSS Pierre-De Saurel to 77.6 for CSSS de la Haute-Yamaska.

- ICIT scores for the "practices" dimension rose for six CSSS territories. The most significant increases were for CSSS de la Haute-Yamaska (+11.7) and Haut-Richelieu–Rouville (+10.4); the most significant decrease among the four CSSS territories for which ICIT scores dropped was for CSSS Pierre-Boucher (-5,7). CSSS de Vaudreuil-Soulanges remained stable. The 2010 ICIT scores varied significantly among CSSS territories for this dimension, ranging from 43.0 for CSSS Pierre-De Saurel to 72.9 for CSSS de la Haute-Yamaska.
- Of the four dimensions, "vision" is the one for which changes among CSSS territories diverged the most. Indeed, we observe higher ICIT scores for two CSSS territories, stable scores for four others and decreases for the remaining five. The increases were limited to CSSS Jardins-Roussillon (+2.2) and Champlain-Charles-Le Moyne (+5.2); however, we should note that, between 2005 and 2010, these two CSSS territories showed no increases in ICIT scores for the other dimensions. Conversely, the ICIT score for "vision" was stable for CSSS Haut-Richelieu–Rouville (+0.5) but its scores for the other dimensions increased sharply. We also note a significant decrease in ICIT score for "vision" (-14.6) and an important increase for "structure" (+21.5) for CSSS Pierre-De Saurel. The 2010 ICIT scores for the dimension "vision" varied widely among CSSS territories, with the highest score for CSSS Haut-Saint-Laurent (82.8) and the lowest for CSSS Pierre-De Saurel (53.6).



Average global score of conformity to ideal type of primary care medical clinics (on 100), by CSSS territory, Montérégie, 2010 (weighted data)

Conclusion

- In the region, we observed a very slight decline in the number of primary care medical clinics between 2005 and 2010 (-4); this decrease, mostly due to small (mostly solo) clinics closures, was compensated by merges and the ongoing implementation of FMG, and the beginning of NC implementation.
- There was also, in the region, clear improvement in the index of conformity to organizational ideal type (ICIT) between 2005 and 2010.
- This improvement was due mostly to existing clinics implementing FMG.
- Given the nature of these changes, we found that ICIT scores for the dimensions “structure” and “resources” were the ones that changed the most.
- The changes related to the “resources” and “structure” dimensions were very similar; moreover, “vision” sometimes appeared to move in the opposite direction of the other dimensions: when it improved, the others often deteriorated, especially the “resources” and “structure” dimensions.
- Finally, while global regional ICIT scores were relatively stable (+1.9), positive changes in some CSSS territories were quite significant, but were hampered overall by the negative changes in other CSSS.
- As a result, in 2010, there were broad disparities among CSSS territories in the region, a characteristic that is undoubtedly a highlight of the findings presented in this report.

AUTEURS

Audrey Couture[1,2], Raynald Pineault[1,2,3], Alexandre Prud’homme[1,2], Sylvie Provost[1,2,3], Roxane Borgès Da Silva[1,2,4], Jean-Frédéric Levesque[1,2,3], Pierre Tousignant[1,2,3]

[1] Direction de santé publique de l’Agence de la santé et des services sociaux de Montréal
[2] Institut national de santé publique du Québec
[3] Centre de recherche du Centre hospitalier de l’Université de Montréal
[4] Université de Montréal

Research team

Project coordinator
Audrey Couture

Principal investigators
Jean-Frédéric Levesque, Raynald Pineault, Pierre Tousignant

Co-investigators and research professionals
Sylvie Provost, Roxane Borgès Da Silva, Odette Lemoine, Brigitte Simard, Marjolaine Hamel, Alexandre Prud’homme, Dominique Grimard, Michel Fournier, Danièle Roberge, Mylaine Breton, Jean-Louis Denis, Marie-Dominique Beaulieu, Debbie Feldman, Paul Lamarche, Jeannie Haggerty, Josée Côté

Co-decision makers
Denis A. Roy, Mylène Drouin, Louis Côté, François Goulet

Translation
Sylvie Gauthier

Production and publishing support
Mireille Paradis

Funding organizations and partners

This study was funded by Canadian Institutes of Health Research (CIHR) and Fonds de la recherche du Québec – Santé (FRQS) along with ministère de la Santé et des Services sociaux du Québec. It also receives financial support from the Agences de la santé et des services sociaux (ASSS) de Montréal and Montérégie, and from the Institut national de santé publique du Québec (INSPQ). The Fédération des médecins omnipraticiens du Québec and the Collège des médecins du Québec have given their support to the project.

The project has received ethical approval from the research ethics committee of the Agence de la santé et des services sociaux de Montréal, the main committee. The multicentre nature of the research project requires ethical approval from research ethics committees in each health and social services centre in the territories under study.

This document is available on the Web sites of the Direction de santé publique (www.dsp.santemontreal.qc.ca/dossiers_thematiques/services_preventifs/thematique/sante_des_populations_et_services_de_sante/documentation.html) and the INSPQ (www.inspq.qc.ca/publications/).

You may cite the data from this document, as long as you specify the source.

© Direction de santé publique, Agence de la santé et des services sociaux de Montréal (2012)
Institut national de santé publique du Québec (2012)

Québec

• Agence de la santé et des services sociaux de Montréa
• Institut national de santé publique

October 2012