



**Project title:**

The implementation of family medicine groups: the challenge posed by the reorganization of practice and interprofessional collaboration

**Researcher(s):**

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**Project objective(s):**

Our project seeks to evaluate the implementation of the first family medicine groups from the point of view of the reorganization of work and professional collaboration in primary care medical teams.

**Hypotheses or research questions:**

The project seeks to answer the following questions: (1) How will family medicine groups redefine the methods of practice and collaboration between different professionals to attain the objectives of the reform? (2) What impact will the reorganization of work have on clinical practice and the feeling of cooperation and, consequently, on the attainment of the objectives of the reform and the satisfaction of clients? (3) How will structural and organizational factors in the internal and external environment affect methods of practice and interprofessional collaboration, on the one hand, and the attainment of objectives, on the other hand? (4) How will the implementation of family medicine groups alter from an ethical standpoint interprofessional collaboration and what effect will the implementation of such groups have on the ethics of the clinical relationship between medical caregivers (physicians and nurses) and patients?

**Sociopolitical context, study population, geographical territory:**

In January 2001, the Commission d'étude sur les services de santé et les services sociaux du Québec made as one of its key recommendations the establishment of family medicine groups. The ability of politicians and managers to create conditions for successful implementation of such health care teams was questioned by a population that was already finding it hard to gain access to a family physician and continuous, coordinated services. Such concerns were not unwarranted since we know that the implementation of the teams would be more or less easy depending on the constraints inherent in each health care system. This project focuses on the implementation of family medicine groups in the Montréal, Estrie, Montérégie and Outaouais regions.

**Theoretical perspective, conceptual framework, intervention logic etc., on which your research is based:**

The theoretical framework underpinning this research integrates existing knowledge on change and professional collaboration in order to fully understand the conditions and processes whereby the family medicine group model will make it possible to consolidate a new form of organization of primary care and produce appreciable effects for patients. We have relied on extensive literature, including the work of certain researchers who are part of our team. The model postulates that the implementation of a new form of organization should lead to new clinical practices and a broader feeling of collaboration, which, in turn, will enable the system to

attain its objectives of accessibility, continuity, coordination and comprehensiveness and the desired perception of quality of care among patients. The family medicine group model can lead to more or less significant changes depending on the intensity of pressure from the environment in favour of change and according to the coherence of the signals sent by the sociopolitical context in favour of the reform of primary health care.

The success of this reform will depend, to a great extent, on the ability of the medical caregivers concerned to develop a feeling of belonging to their organization and efficient means of collaboration. This explains the importance that the study attaches to the process advocated by the teams to develop professional collaboration. We have adopted the model of structuring collaboration among health care professionals proposed by D'Amour (1999), which conceives of the development of collaboration as a dynamic process encompassing a number of interrelated dimensions.

### **Description of the specific aspects of primary care services organisation studied in your project:**

**Vision or organisational culture** (*responsibility toward population or clientele, service vs health finality, etc.*)

Responsibility to a clientele

#### **Organisational structure**

1. Governance (*professional vs community-based, relations between actors stemming from regulations or laws, payment in the form of incentives, etc.*)

Professional governance; Bill 90; financial incentives associated with accreditation as a family medicine group.

2. Integration/coordination (*organisational/functional, clinical, strategic, systemic, external, internal, etc.*)

Integration/coordination, above all clinical and internal in the health care milieu; certain components of organizational integration by means of agreements between family medicine groups and local community service centres (CLSCs) and between family medicine groups and the Agence de développement de réseaux locaux de services de santé et de services sociaux (ADRLSSSS)

#### **Resources**

1. Type (*human, financial, physical, technological, etc.*)

Human, financial and technological

2. Level (*quantity, distribution*)

3. Substitution (*do primary care services substitute for specialised services?*)

No

#### **Practices**

1. Multidisciplinarity/interdisciplinarity

The family medicine group creates a new team and integrates the nurse and family physicians

2. Interprofessional, interorganisational collaboration process

Interprofessional collaboration above all but also interorganizational collaboration (service coverage agreements between family medicine groups; agreement between the CLSC and the ADRLSSSS)

3. Services offered (*scope, range*)

Standard family medicine services, including obstetrics and home follow-up; certain family medicine groups offer hospital services

4. Mechanisms to ensure continuity, accessibility, comprehensiveness

Possible formal links between Info-Santé and family medicine groups; evening and weekend consultations; a broader role for nurses (telephone consultation); preventive and educational services; treatment of chronic diseases

## Effects

### 1. Profile of use

Changes in the clinical practices of physicians and nurses; intensity of collaboration

### 2. Continuity, comprehensiveness, accessibility, responsiveness

Survey of a sample of patients using the "Questionnaire sur la continuité des soins au Québec" (Haggerty *et al.*, measurement of continuity, accessibility, comprehensiveness and responsiveness)

### 3. Health

No

## Research strategy:

The cases were selected in order to contrast two structural characteristics deemed to be fundamental, bearing in mind research questions: the type of organization and the employment link between physicians and nurses. From an organizational standpoint, we will be sure to include two family medicine groups-CLSCs and two family medicine groups-private clinics. Moreover, we will ensure that we examine a family medicine group integrating CLSC nurses in a private clinic and a family medicine group integrating nurses who are already part of the group. We agreed with our partners that the final choice of cases cannot be made before the submission of the agreement binding the family medicine group and the Regional Board, i.e. next June.

The project proposes an analysis of family medicine group development processes in order to compare them with measurements of results. We are proposing an analysis of the process of development of professional collaboration and its interaction with a series of factors favourable to change management. The objectives have been conceptualized as intermediate objectives and what we deem to be ultimate objectives, i.e. the attainment of the objectives covered by the reorganization of primary care, including the clientele's perception of the quality of care. We believe that it is possible to observe the results in relation to the objectives pursued once the family medicine groups have been in operation for two years.

## Studied variables:

Clinical practices (logbook and questionnaire); intensity of collaboration; perception of the effects by a sample of patients

## Research design

Case analysis

## Sample (type, size)

Five family medicine groups employing roughly 40 physicians and 10 nurses. Before-and-after surveys of 1500 patients (300 per family medicine group).

## Measurement scales, data collection tools and sources:

Review of literature, interviews and questionnaires

## Type of analysis (quantitative, qualitative, triangulation):

Quantitative and qualitative. Triangulation insofar as different medical caregivers are being asked to describe the implementation process from their own perspective. Potential triangulation by the review of literature and the findings of a survey of users, e.g. the perception of professionals of enhanced accessibility and continuity as opposed to the perception of users. Validation by the participants of the information.

**Period of time covered by the study:**

July 2003 to September 2005

**Results, aspects of the approach specially pertinent for decision-makers:**

The preliminary findings are available with respect to clientele likely to register with family medicine groups and procedures adopted to structure collaboration.

With regard to the clientele, the findings of the survey conducted among 1500 patients (300 per family medicine group) reveal that the clientele are generally more demanding than the patients registered with a medical practitioner in a country such as England. Indeed, 60% of the patients, on average, are affected by at least one chronic health problem; 25% deem their health to be acceptable and 9%, poor. The patients interviewed said they had seen their physician five times, on average, during the year.

As for collaboration, it is undergoing structuring in all of the family medicine groups studied but is still far from being established. The implementation of the family medicine groups is extensively mobilizing the teams.

Already, these findings are likely to be useful to decision-makers. For example, they suggest that we must proceed cautiously and continue to observe the characteristics of clientele before we establish the average number of patients to be registered per physician. The number suggested by the Clair report, i.e. 1200 per physician, seems high if the clientele that register are indeed more demanding than a clientele drawn from a populational base, as is the case in England. It is unrealistic to expect the family medicine group's potential in terms of accessibility and coordination to become apparent for at least two years.

**Your opinion on the convincing nature of your results for decision-makers:**

	Little	Somewhat	Very much	N.A.*
<b>Internal validity: how confident are you about the strength of the relation between your variables based notably on:</b>				
• Research design	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Sample size ( <i>statistical power</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
• Intervention analysis ( <i>logic/theory of intervention</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
• Implementation analysis ( <i>synergy, antagonism with context elements</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>External validity: how easily can your results be applied in other contexts based notably on:</b>				
• Size of reference population, diversity of studied cases	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Statistical inference ( <i>inference of sample to sampled population</i> )	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Implementation analysis ( <i>can implementation conditions be found in another context, ability to replicate</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
• Intervention analysis ( <i>theoretical inference stemming from the fact that the studied intervention is based on an explicit intervention theory which can be applied in another context</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

<b>Applicability: how easily can your results be used by decision-makers based on what you know to be constraints or barriers or elements facilitating their application:</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Describe constraints: Difficulty in dealing with certain internal group dynamics bearing in mind their previous history; certain departmental decisions that risk affecting the dynamic, e.g. the moratorium on the establishment of family medicine groups; new dynamics created by the establishment of networks, and so on.				
Describe facilitating elements: Ability of key medical caregivers to act in respect of different dimensions of the implementation process, in particular on the management of human resources and support for change.				

\*N.A.: Not applicable.

**Financing sources:**

Canadian Health Services Research Foundation (CHSRF), Fonds de recherche en santé du Québec (FRSQ), and Direction de l'évaluation, ministère de la Santé et des Services sociaux du Québec (MSSS)

**Knowledge exchange strategies:**

(1) Periodic meetings with the advisory committee made up of the key decision-makers involved to discuss the preliminary findings; (2) validation of the findings by the family medicine group teams under study; (3) integration into the research team of a researcher-decision-maker. Dissemination strategies will be elaborated in collaboration with the decision-makers.

**Anticipated fall-out or use in planning or decision-making:**

TARGETTED DECISION-MAKERS (administrative, clinical)	FALL-OUT
Policy and program managers (MSSS, Agences régionales)	Conditions that make it possible to achieve significant changes with respect to professional practice and health care offered to the public in a gradual manner without major breaks with the rules and forms of organization now in effect.
Organisation managers (CH, CLSC, GMF, CMA, etc.)	Processes that can help establish genuine group practices; how to foster the coordination of different professionals within these change processes; pinpoint the most promising strategies for guiding change.
Professional groups/ associations	Processes that can help establish genuine group practices; how to foster the coordination of different professionals within these change processes; pinpoint the most promising strategies for guiding change.  Planning of initial and ongoing training of health professionals and professional skills maintenance.
Community groups	
Other:	

**What promising research avenues stem from your project, on the same issue or on a new issue?**

The findings will make it possible to consolidate knowledge of change in organizations and the development of professional collaboration. In particular, they will enable us to ascertain whether certain change management practices are more promising than others depending on the stage of structuring of collaboration achieved by the teams. The findings are also likely to have an impact on the development of models of group practice adapted to current conditions, a topical factor in Canada and European. We also envisage consequences in the realm of professional training concerning new clinical and administrative skills to be acquired and the training methods to achieve this end. In the realm of ethics, we will be able to shed light on questions that have scarcely been studied concerning the concept of practice and team responsibility.

**Main key words:**

Professional collaboration, change management, primary care clinical practices, family medicine group