



RÉGIE RÉGIONALE
DE LA SANTÉ ET DES
SERVICES SOCIAUX
DE MONTRÉAL-CENTRE

*Quality
care
for
everyone*

*PROGRAMME FOR CONTINUOUS
IMPROVEMENT IN SERVICE QUALITY AND
USER SATISFACTION*

Report

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JUNE 1999*

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Introduction

In the fall of 1996, the *Régie régionale de Montréal-Centre* (Montréal's Regional Board of Health and social services) launched its "Programme for continuous improvement in service quality and user satisfaction" with a press conference at Ste. Justine Hospital, attended by representatives of the 20 institutions selected as pilot sites. The Regional Board hoped to further develop the service concept defined by users from the region in the 1994 survey by adapting the concept to suit the particular needs of various categories of institutions and target clienteles that were not reached by the initial survey. The *Ministère de la Santé et des Services sociaux* joined the Regional Board in supporting the regional programme through the "*fonds de soutien à l'innovation*". The Ministry contributed \$240,000 of the total of nearly \$680,000 that was made available to the institutions.

Two years later, the experiments at the pilot sites have been practically completed, despite major changes that disrupted the flow of activities. This final report was prepared to wrap up the experiment and provide an opportunity for other institutions to benefit from the tools and techniques that were developed during the project.

TABLE OF CONTENTS

1 A BRIEF DESCRIPTION OF THE REGIONAL PROCESS FOR CONTINUOUS IMPROVEMENT IN SERVICE QUALITY AND USER SATISFACTION	5
1.1 MINISTERIAL ORIENTATIONS	6
1.2 SERVICE CONCEPT	6
1.3 THE REGIONAL PROCESS FOR CONTINUOUS IMPROVEMENT IN SERVICE QUALITY	8
1.4 REGIONAL SERVICE CONCEPT	9
1.4.1 What users expect from the health and social service system.....	10
1.4.2 Relative importance of expectations.....	13
1.4.3 Impact on users' overall satisfaction level.....	14
1.4.4 Conclusion.....	14
1.5 RESULTS OF SATISFACTION SURVEY OF MONTREAL USERS.....	15
1.6 RESULTS OF THE 1994 SATISFACTION SURVEY.....	15
1.6.1 Satisfaction rates observed.....	16
1.6.2 The most important problems.....	17
1.6.3 Strong and weak points	18
1.7 1997 SATISFACTION SURVEY.....	19
1.7.1 Use of facilities - comparison between 1994 and 1997.....	19
1.7.2 Satisfaction rates observed.....	21
1.8 SATISFACTION SURVEY OF USERS REFERRED BY HOSPITALS TO POST-DISCHARGE SERVICES AT CLSCs	23
1.9 FOCUS GROUPS	24
2 IMPROVING SERVICE QUALITY	26
2.1 MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX.....	26
2.2 RÉGIE RÉGIONALE DE LA SANTÉ ET DES SERVICES SOCIAUX.....	26
Link with regional service organization plans	27
2.3 INSTITUTIONS.....	27
3 EXPANDING THE PROGRAMME FOR CONTINUOUS IMPROVEMENT	28
3.1 SUPPORTING STEPS TAKEN BY INSTITUTIONS	28
3.2 SUPPORTING "QUALITY" GROUPS	29
3.3 DISSEMINATING EXPERTISE DEVELOPED IN IMPROVING SERVICE QUALITY	30
3.4 STEPPING UP RESEARCH AND EXPERIMENTATION EFFORTS.....	30
3.5 BUILDING THE CONTINUOUS IMPROVEMENT PROCESS INTO SERVICES PROVIDED BY THE RÉGIE RÉGIONALE ...	30
3.6 CHANGING THE PROCESS FOR INSTITUTIONAL ACCOUNTABILITY	30
4 PILOT SITES	31
4.1 CASCADE OF SERVICE CONCEPTS	31
4.2 EXPANDING THE PILOT SITE EXPERIMENTS	43
4.3 COMPUTER SYSTEMS SUPPORT, RETROACTIVE LOOK AT THE USERS' PERSPECTIVE	43
4.4 RECOMMENDATIONS MADE BY INSTITUTIONS THAT SERVED AS PILOT SITES.....	44
5 RECOMMENDATIONS TO THE MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX.....	47
5.1 A MOBILIZING STRATEGY FOR ALL OF QUEBEC	47
5.2 BUILT-IN ACCOUNTABILITY	48
5.3 DEVELOPING A COMPUTER SUPPORT SYSTEM.....	48
5.4 HUMAN RESOURCES: IN SEARCH OF EXCELLENCE.....	48
5.5 A COMMUNICATIONS STRATEGY DESIGNED TO REACH QUEBECKERS	49
BIBLIOGRAPHY	50

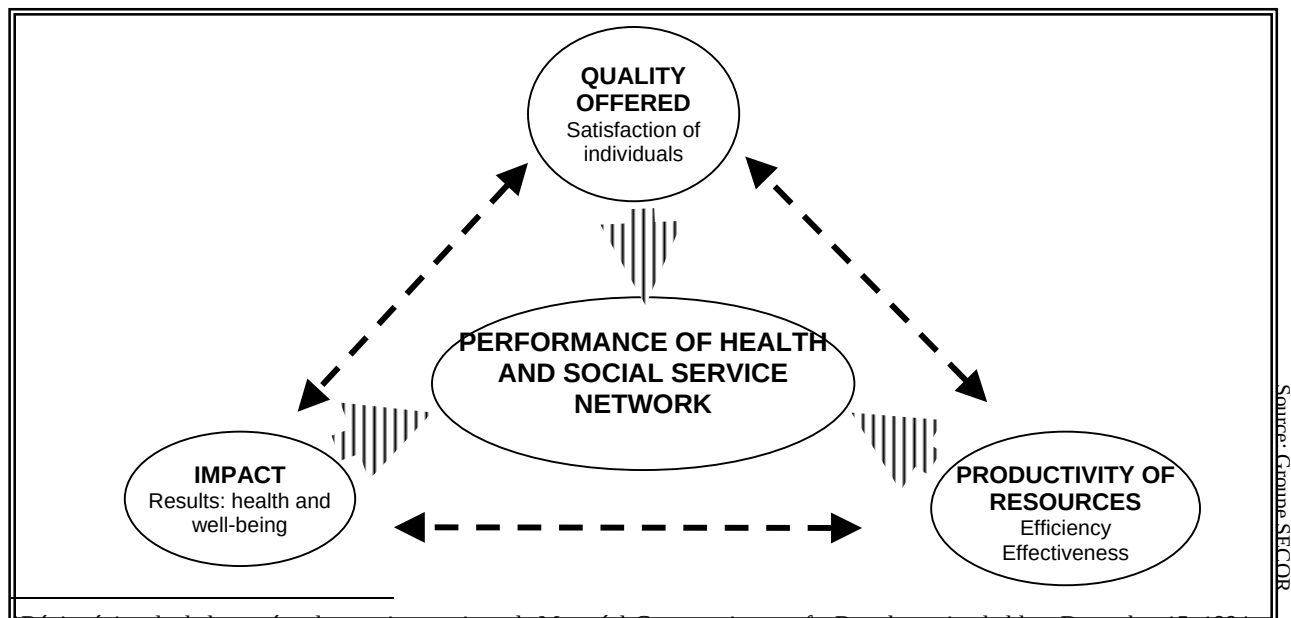
1 A brief description of the regional process for continuous improvement in service quality and user satisfaction

On December 15, 1994, the Board of Directors of the *Régie régionale de Montréal-Centre* adopted orientations designed to improve the quality of services, approaching quality from the viewpoint of citizens' level of satisfaction with the services they are offered¹. Since quality is defined as the extent to which clients' real needs are met, ultimately it must be the users who judge the overall quality of the services they use. In selecting such an orientation, the Regional Board worked jointly with the accreditation bodies, i.e. the Canadian Council on Health Services Accreditation and the Conseil québécois, while avoiding duplication of efforts with other regulatory bodies such as professional corporations and internal groups at each institution: the Council of Physicians, Dentists and Pharmacists, Council of Nurses, and Multidisciplinary Council.

The health and social service network in the Montreal-Centre region is broad-based and complex. Including physicians' salaries, taxpayers spend \$4.2 billion a year on 450 polyclinics and physicians' offices, 144 institutions and 455 community groups².

The concept of user satisfaction is the cornerstone of the ongoing process of improving the quality of health and social services. To this end we have adopted a service concept and acquired the necessary tools to monitor users' satisfaction on a regular basis. The level of users' satisfaction is a key aspect of performance evaluation, as shown in Figure 1.

FIGURE 1



Source: Groupe SECOR

¹ Régie régionale de la santé et des services sociaux de Montréal-Centre, minutes of a Board meeting held on December 15, 1994.

² Régie régionale de la santé et des services sociaux de Montréal-Centre, Annual Report 1996-1997.

1.1 Ministerial orientations

In the fall of 1998, the Minister of Health and Social Services identified four priorities for the next three years. One of these priorities involves ensuring the provision of quality services. The priority designed to improve service quality requires that “user satisfaction be made an objective that can be evaluated in assessing the performance of institutions and service providers”³.

1.2 Service concept

In order to evaluate user satisfaction, we must first identify users’ expectations; based on these concerns, we can then define a service concept. The service concept thus becomes the frame of reference for assessing user satisfaction.

As shown in Figure 2, in the health and social service system it is imperative that service provision be organized in such a way as to serve the citizens, who have simultaneous 1) needs, 2) rights and 3) expectations.

These elements can be grouped together into a number of dimensions that define the various components found in the health and social service system.

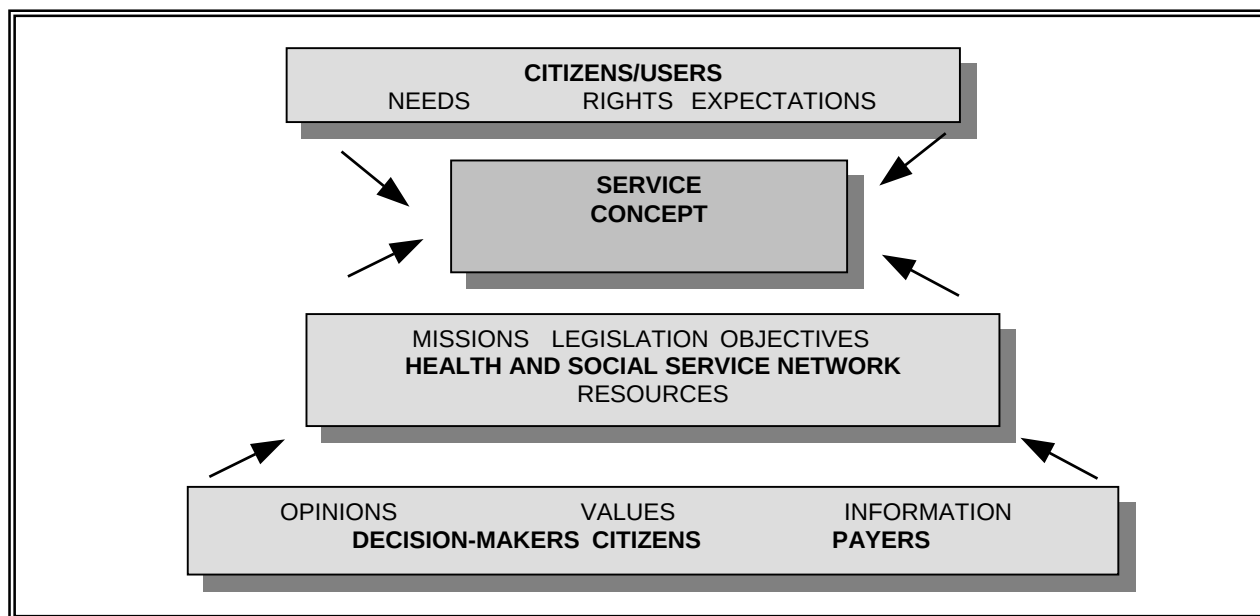


FIGURE 2

Adopting a service concept involves selecting priorities from among all the possible dimensions. This also means that a position must be taken regarding those dimensions that are considered a priority. A commitment must be made to users that quality standards will be attained in these dimensions both in their design and delivery. Dimensions that make up

³ MSSS, Les services à la population 1998-1999 à 2000-2001

the service concept will be monitored and promoted in a regular, sustained manner, and concrete steps will be taken to improve them.

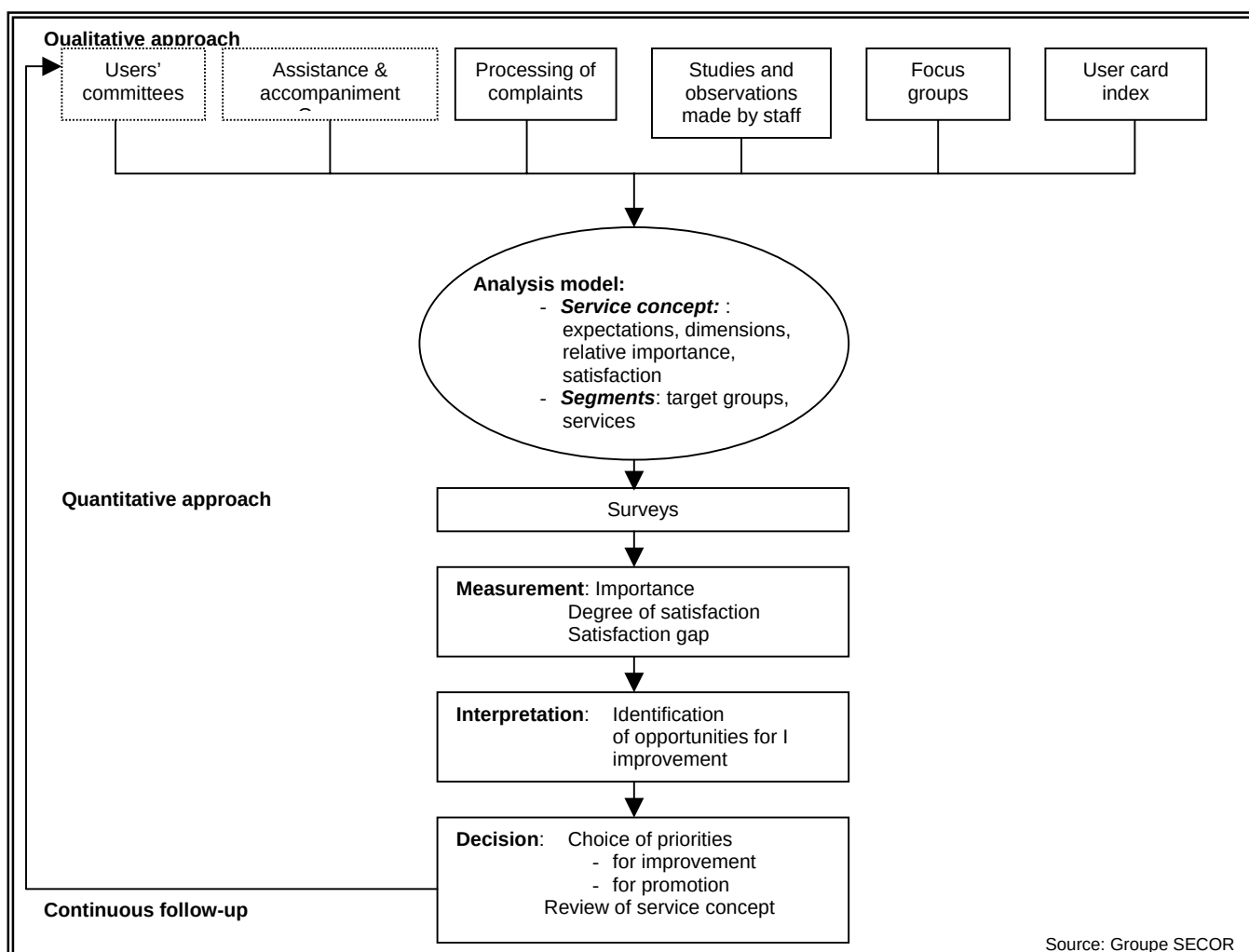
1.3 The regional process for continuous improvement in service quality

There is no point in evaluating user satisfaction unless the process gives the network partners an opportunity to make changes to better respond to the needs and expectations of the public. Evaluation leads to improvement. The process – evaluating changes in service provision and evaluating results – becomes an ongoing process designed to improve service quality.

Figure 3 presents the general process for ongoing improvement in the quality of services to users adopted by the Regional Board. The two following fundamental principles guided the Board in establishing the process:

- something that has not been measured can not be improved upon and we have no way of knowing whether there has been any improvement if no measurements have been taken;
- we need to measure service quality in order to establish priorities for improvement and promotion, not in order to sanction and control.

FIGURE 3



On the qualitative level, the primary tool remains the survey – a poll of a representative sampling of users.

In the health and social service network, it is obviously easier to reach the clientele of multiclientele services i.e. medical clinics, CLSCs and acute care hospitals by way of general population surveys.

Certain segments of the clientele, specifically patients receiving long-term care, rehabilitation services, those in youth protection centres and psychiatric hospitals, will require a different approach through the use of specific surveys and or the use of alternative measurement tools.

Different qualitative and quantitative instruments provide an opportunity to measure:

- the importance users attach to various dimensions of service quality in the field of health and social services;
- users' degree of satisfaction with these dimensions and the gaps in satisfaction levels from one dimension to the next.

Interpreting all these data in the light of our analysis model (regional service concept), enables us to identify cyclical opportunities for improving various dimensions of service quality.

The next step involves making decisions on priorities, i.e.:

- improving the quality of one or more dimensions of the service concept;
- promoting one or more dimensions of the service concept.

Further more, analysing various data relating to values, objectives and resources can lead to a revision of the service concept and the commitments made to users of the health and social service network.

Since users must be in the foreground of change, the first step in developing a service strategy logically involves measuring users' expectations and satisfaction levels.

In fact, without serious and ongoing measurements of satisfaction levels, improvement and quality programs do not last. Too often, they disappear into vague statements, without a solid foundation or supporting references.

1.4 Regional service concept

In May 1994, the Regional Board, with the help of *Secor* and *Zins Beauchesne et associés*, conducted a survey of the population of Montreal.

- The first step was to complete the definition of the service concept in health and social services by identifying what expectations the population has of these services and establishing their relative degree of importance.

- The second step involved measuring users' level of satisfaction in regard to the expectations and dimensions in the service concept. See Section 2 for a summary of the results.

Expectations were identified through focus groups made up of members of the principle target groups in the network, and through a telephone survey based on a representative sampling of 4,000 people aged 15 and over, residents of the Montreal Urban Community.

1.4.1 Users' expectations of the health and social service network

This initial step in the process enabled the Regional Board to identify the service concept to be used as a reference point in the regional strategy for the continuous improvement in service quality and user satisfaction. Some adjustments were made to the service concept for the second survey, which was conducted in 1997.

According to the survey findings, **quality service** should provide an appropriate response to users' expectations in three sectors of activity that combine the twelve (12) dimensions illustrated in Figures 4a, 4b and 4c.

FIGURE 4a

RELATIONAL SECTOR		
This sector, which involves relationships with users, covers humane treatment and aspects of service that users consider extremely important.		
DIMENSION	DEFINITION	EXPECTATION (STATEMENTS)
Dignity	Dignity means the respect and consideration to which everyone is entitled.	- You are treated with respect (#1) - Your choices are respected and you are not forced to participate in particular activities (#21) - Staff not only deal with your immediate problem, but treat you as a whole person (#2) - Staff consider your culture and lifestyle (#22) - Everyone is treated equally, without any form of discrimination (#20)
Privacy	Privacy means that individuals receive personalized, confidential and safe treatment. This requires an environment that is physically comfortable, and attentive, discreet behaviour.	- You are not asked questions that have nothing to do with your problem (#3) - Staff deal with you in a discreet way (#23) - Your case is handled confidentially (#4) - Your physical privacy is respected by the institution (#24)
Empathy	Empathy involves understanding others' feelings. This implies active listening.	- Staff take the time to deal with you (#15) - Caregivers listen to you attentively and take you seriously (#16) - Staff show consideration for members of your family who are helping you (#35) - Staff understand you properly (#36)

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FIGURE 4b

PROFESSIONAL SECTOR		
This sector, which covers the provision of professional services, refers to specific professions, expertise and ways of meeting basic needs through treatment.		
DIMENSION	DEFINITION	EXPECTATION (STATEMENT)
Reliability	Reliability means the assurance that everything will go smoothly within known, reasonable limits (e.g. time and environment), as promised either implicitly or explicitly. This involves competence, consistency, thoroughness and transparency.	• Appointments are kept on time (#13) • You are able to assert your rights if you are not satisfied with the services offered (#33) • Staff are competent (#34) • You are given the results of any examinations and tests you have (#14)⁴
Responsibility	Responsibility is everything that helps to increase an individual's autonomy and capacity to take initiatives, assume responsibilities and exercise leadership in his or her own regard.	• Caregivers present the various choices available (#5) • Caregivers help you find your own solution (#6) • No one makes decisions on your behalf (#25) • Caregivers advise you on how to avoid a recurrence of the problem (#26)
Reassurance	Reassurance is the ability to calm and reassure a person and make him or her feel secure.	• Caregivers take the time to give a full step-by-step explanation of what is happening (#18) • Staff are cheerful (#38)
Solidarity	Solidarity involves everything that encourages the patient to reach out to his or her family and community to get them involved in solving problems, to a greater or lesser degree.	• The institution encourages you to get support from family, friends and community groups (#19) • You are put in contact with other people or associations of people who have experienced similar problems (#39)

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⁴ This statement was slightly different in the 1997 survey.

FIGURE 4c

ORGANIZATIONAL SECTOR		
This sector, which involves service organization, covers the environment, contacts and relationships between users and caregivers. The context may be helpful or not so helpful, with a certain comfort level: service may be more or less accessible, and systems, policies and procedures may or may not be designed to ensure rapid service, continuity and facility of service.		
DIMENSION	DEFINITION	EXPECTATION (STATEMENTS)
Facility	Facility means services that are easy to use, easy to understand and flexible in various circumstances. "Easy" applies to both the people involved (whose behaviour should be natural, spontaneous and unpretentious) and the things involved (which should be easy to understand and use).	• There are not too many formalities in your dealings with the institution (#7)⁵ • You are spoken to in a way you can understand (#27) • You feel that you can choose your caregivers or switch if things do not go well (#8)⁶ • You are given all the information you need on where to go, what to do and what not to do (#28)
Continuity	Continuity is the assurance that users will receive full treatment, without any interruptions in case management, responsibilities or information.	• You feel that there is continuity and a good flow of information between various health resources in Montreal (#9)⁷ • The same caregivers see you on each visit (#29)
Accessibility	Accessibility means that the institution is accessible in terms of geography, physical facilities, schedules and culture.	• The institution is easily accessible via public transit or has parking nearby (#10) • The institution provides information on all the services it offers (#11) • The information you are given is adapted to your culture and language (#30) • The institution is open at convenient times (weekdays, weekends, and/or evenings) (#31)⁸
Rapidity	Rapidity means how long it takes to get a response to a request, depending on the client's expectations and needs.	• You can make an appointment to see a professional quickly (#12)⁹ • If you don't have an appointment, you don't have long to wait (#32)¹⁰
Comfort	Comfort is the feeling of well-being users get from being in sanitary, clean and orderly surroundings, with equipment that can be adapted to various situations.	• The atmosphere in the institution is pleasant (#17) • The premises and equipment are clean (#37)

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⁵ This statement was slightly different in 1997.

⁶ This statement was slightly different in 1997.

⁷ This statement was slightly different in 1997.

⁸ This statement was slightly different in 1997.

⁹ This statement was slightly different in 1997.

¹⁰ This statement was slightly different in 1997.

Expectations were identified in relation to the overall health and social service network. For users living in institutions such as a long-term care centres or rehabilitation centres, there were additional expectations that came under the heading of comfort: good food, not mixing different types of residents, activities adapted to personal preferences and needs, etc.

The most significant finding that emerged from this survey was learning what is really important for users in terms of service quality and which specific dimensions are of greatest concern to them.

1.4.2 Relative importance of expectations

Not all the dimensions and expectations are of equal importance. As shown in Figure 5, the degree of importance for users and the level of demand vary from expectation to expectation and from dimension to dimension.

Generally speaking, the average level of users' expectations is high. The most important expectation is that staff be competent; the expectation that ranked last was to be put in contact with others who have experienced similar problems.

FIGURE 5 - The six expectations users consider most important

ORDER	EXPECTATION	SCORE/10	DIMENSION
1.	Staff are competent	9.67	RELIABILITY
2.	You are treated with respect	9.64	DIGNITY
3.	The premises and equipment are clean	9.59	COMFORT
4.	Everyone is treated equally, without any form of discrimination	9.50	DIGNITY
5.	Your case is handled confidentially	5.50	PRIVACY
6.	Caregivers listen to you attentively and take you seriously	9.48	EMPATHY

Source: GROUPE SECOR

Four of the six expectations considered most important clearly relate to dimensions (dignity, empathy, privacy) that involve personal relationships with users, while the other two involve the competence of professionals and the cleanliness of the premises.

Figure 6 shows the six dimensions considered to be most important.

FIGURE 6 -The six dimensions users consider the most important

ORDER	DIMENSION	SCORE/10	SECTOR
1.	EMPATHY	9.28	RELATIONAL
2.	RELIABILITY	9.23	PROFESSIONAL
3.	COMFORT	9.15	ORGANIZATIONAL
4.	DIGNITY	9.03	RELATIONAL
5.	RESPONSIBILITY	8.94	PROFESSIONAL

6.	PRIVACY	8.88	RELATIONAL
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Source: GROUPE SECOR

Generally speaking, the relational dimensions are more often considered to be important, with dimensions related to professional and organizational aspects generally following in that order.

1.4.3 Impact on users' overall satisfaction level

All expectations and dimensions do not all have an equal impact on users' overall level of satisfaction. The survey shows that the following dimensions and expectations have the greatest impact on users' overall satisfaction level.

FIGURE 7 – Dimensions and expectations, in order of importance for satisfaction

ORDER	DIMENSION	EXPECTATION
1.	EMPATHY	- Staff take the time to deal with you. - Staff understand you.
2.	DIGNITY	- You are treated with respect. - Staff not only deal with your immediate problem, but treat you as a whole person.
3.	RELIABILITY	- Appointments are kept on time. - Staff are competent.
4.	REASSURANCE	- Caregivers take the time to give a full step-by-step explanation of what is happening. - Staff are cheerful.
5.	RAPIDITY	- You can make an appointment to see a professional quickly. - If you don't have an appointment, you don't have long to wait.
6.	COMFORT	- The atmosphere is pleasant.

Source: GROUPE SECOR

These six (6) dimensions and eleven (11) expectations are those that have the greatest immediate impact on the overall satisfaction rate; however, this does not mean that other dimensions and expectations are not more important or equally important to users and institutions in the network.

1.4.4 Conclusion

This initial phase enabled the Regional Board to develop a regional service concept that reflects both users' expectations and the Board's orientations in terms of service quality.

While the relative importance of expectations and dimensions varies according to different factors that relate to characteristics of users and services, the **3 sectors, 12 dimensions** and **39 expectations** that were identified made it possible to develop a detailed regional service

concept.

1.5 Results of satisfaction surveys of Montreal users

To date, the Regional Board, together with the SECOR group, has conducted two surveys of the general population to evaluate the level of satisfaction with health care and social services. The first survey was conducted in May 1994 and the second three years later, in May 1997.

1.6 Results of the 1994 satisfaction survey

As we have seen, the first phase, designed to identify users' expectations, enabled the Regional Board to fully develop the regional service concept. The second phase, designed to ascertain the satisfaction level of Montreal users, measured satisfaction levels relative to the expectations and dimensions that are part of the service concept. The survey involved 4,000 respondents.

Notwithstanding the constraints and complexity of the network, the Regional Board was able to obtain an accurate and comparable measurement of users' satisfaction with services provided by medical clinics, CLSCs and hospitals, but not with other categories of institutions.

On a yearly basis the services provided by medical clinics, CLSCs and hospitals reach nearly 80% of the population.

For other institutions in the network (youth centres, residential and long-term care centres, rehabilitation centres and psychiatric hospitals), the Regional Board collected qualitative information from focus groups, from the complaint-handling process and from the satisfaction survey of all other service recipients.

As shown in Figure 8, the results have been interpreted using two calculation methods: weighted averaging and the percentage of very satisfied clients.

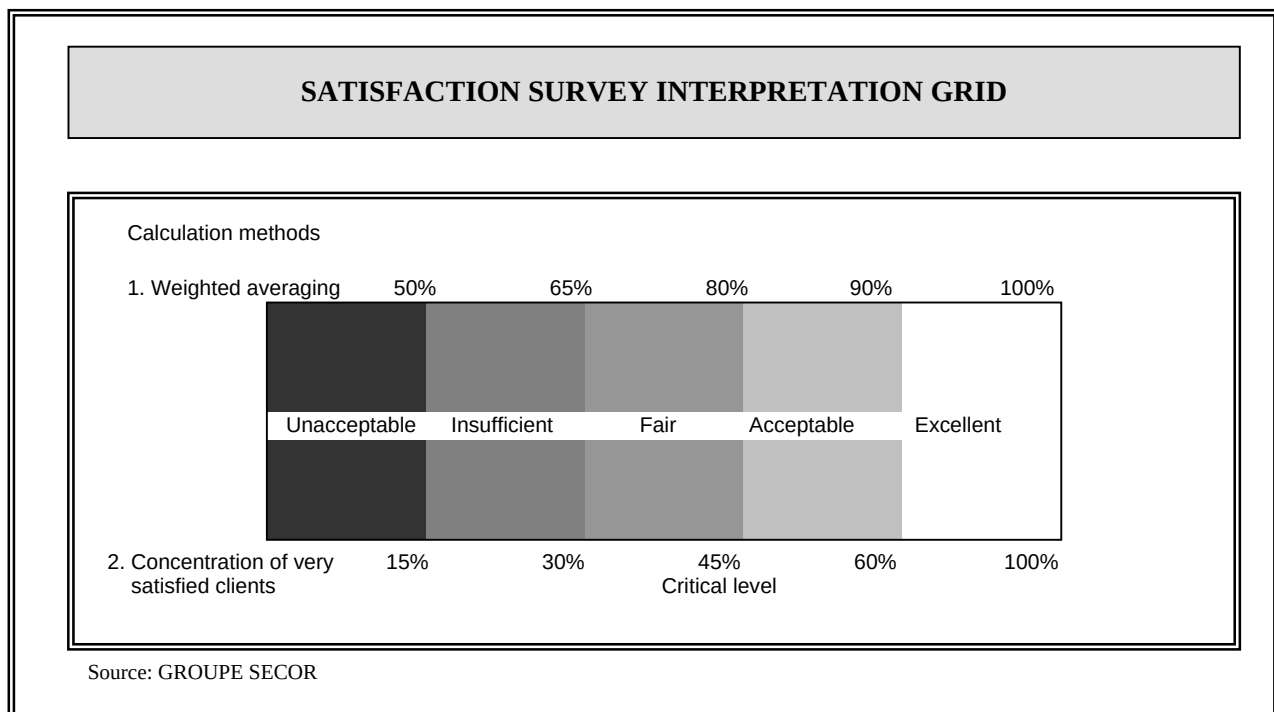


FIGURE 8: Satisfaction survey interpretation grid

By analyzing the findings, the Board was able to identify the strengths and weaknesses of CLSCs, hospitals and private medical clinics and design a programme to improve service quality. In June 1995, the Board of Directors of the "Régie régionale de Montréal-Centre" adopted an initial three-year plan designed to better meet the needs of the population¹¹.

1.6.1 Satisfaction rates observed

Based on the satisfaction survey interpretation grid shown above, users rated the quality of health and social services they received as "fair. "

AVERAGE SCORES OBTAINED				
TOUS LES ORGANISMES	LES C.L.S.C.	CLINIQUES MÉDICALES	CENTRES HOSPITALIERS	AUTRES ORGANISMES
71,18%	70,91%	71,7%	68,66%	71,6%

Source : Groupe SECOR

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FIGURE 9

All of the facilities assessed were rated in the "fair" zone, with the "acceptable" zone starting at 80% and the "excellent" zone at 90%. Clearly, there is room for improvement in all sectors.

"it should not be forgotten that these scores always refer to general averages and that statistics never concern one particular institution. Of course, any one institution could obtain user satisfaction scores higher than those presented here...or, on the other hand, lower."¹²

These findings confirmed the importance for all service providers of implementing an effective and integrated strategy for quality improvement. The objective being that quality does improve and users' satisfaction rates move up from the fair to the excellent range rather than down to the insufficient or unacceptable end of the continuum.

The results shown in Figure 10 are equally valid for private medical clinics as for public institutions – CLSCs and hospitals.

FIGURE 10

ORDER	EXPECTATION	% AVERAGE	% VERY SATISFIED
1.	STAFF ARE COMPETENT	78% FAIR	39% FAIR

¹¹ Régie régionale de Montréal-Centre, Plan to reorganize health and social services on the Island of Montreal, Achieving a new balance, June 1995.

¹² Groupe SECOR et Zins, Beauchesne et Associés, Résultats de l'enquête de mai 1994

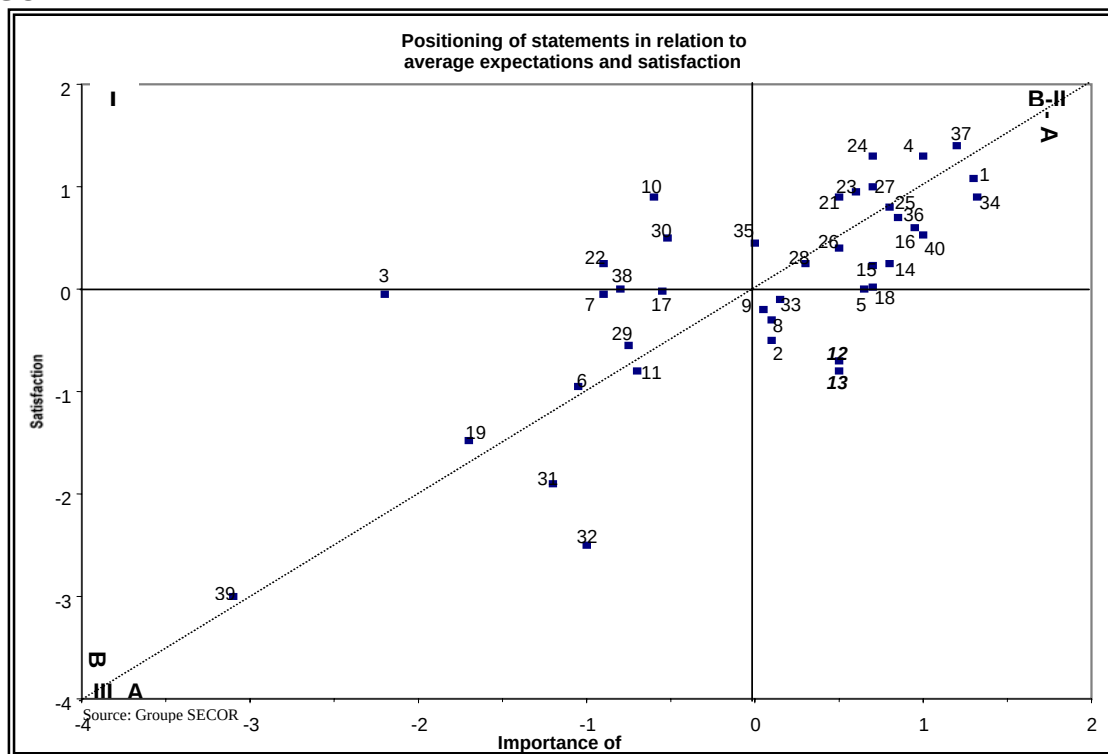
2.	YOU ARE TREATED WITH RESPECT	79% FAIR	42% FAIR
3.	PREMISES AND EQUIPMENT ARE CLEAN	81% FAIR	48% FAIR
4.	EVERYONE IS TREATED EQUALLY, WITHOUT ANY FORM OF DISCRIMINATION	75% FAIR	36% FAIR
5.	YOUR CASE IS HANDLED CONFIDENTIALLY	80% FAIR	44% FAIR
6.	CAREGIVERS LISTEN TO YOU ATTENTIVELY AND TAKE YOU SERIOUSLY	75% FAIR	37% FAIR

Source: Groupe SECOR

1.6.2 The most important problems

If we consider both the degree of importance and the level of users' satisfaction, it becomes clear that there is a major problem in terms of at least two expectations (#12 and #13, as shown in Figure 11).

FIGURE 11



The two expectations, as described in Figures 4b and 4c, are:

- #13: Appointments are kept on time.
- #12: You can make an appointment to see a professional quickly.

For these expectations, the level of importance is higher than average and the rate of satisfaction is clearly lower.

When we look at clients who say they are very satisfied, all of the facilities rate in the insufficient zone.

More or less the same trend is observed when it comes to keeping appointments on time, with hospitals and medical clinics rating in the insufficient zone this time.

For both these expectations, the results for facilities other than hospitals, medical clinics and CLSCs show a higher satisfaction rate.

Analyzing satisfaction and complaints sheds additional light on the relative evaluation of these problems.

For hospitals, the major complaints were about long waits for services such as admission from the emergency room to a bed on a ward, specimen centres ?, telephone response and elective surgery.

For CLSCs, there were complaints about long waits for access to home-care programs, the intensive home-care programme for the handicapped, specimen collection services ? and medical services.

For youth centres and rehabilitation centres (for both physical and intellectual impairments), most of the well-founded complaints concerned long waits for access.

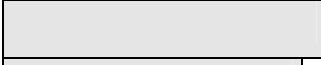
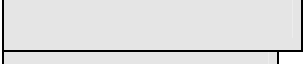
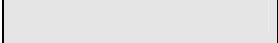
At this time, apart from for-mentioned service sectors, the clients who have the most severe problems to cope with and for whom the service quality is currently the lowest in terms of quick access are the following:

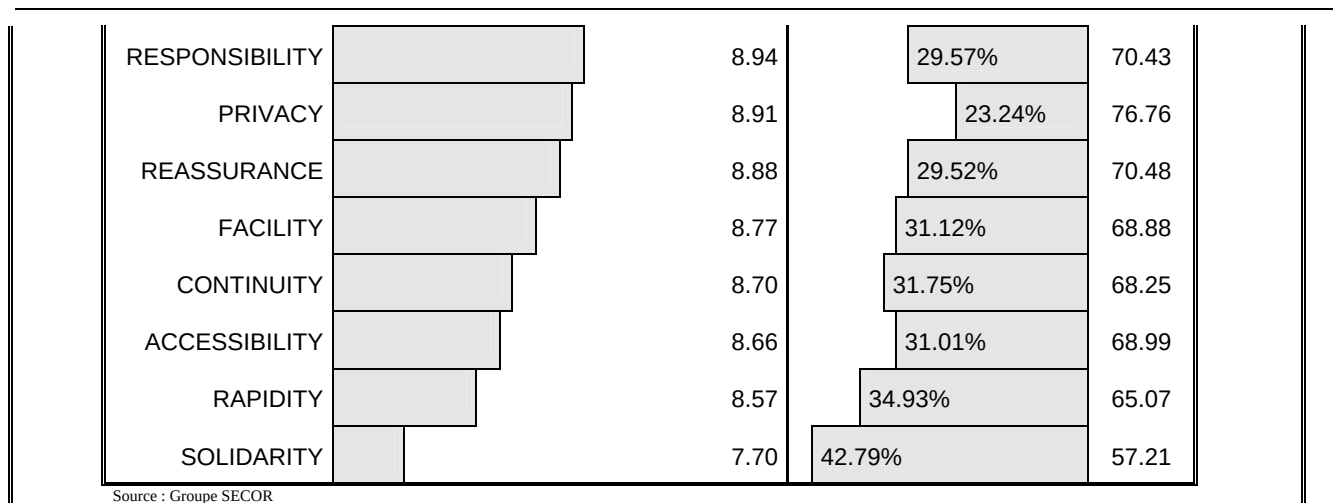
- Individuals with intellectual and multiple impairments
- Individuals with physical impairments

1.6.3 Strong and weak points

Considering both the importance of expectations and the number of very satisfied clients, the survey identified the weakest and strongest points of the various institutions in the network, as shown in Figure 12.

FIGURE 12

ASSESSMENT OF SERVICE DIMENSIONS FOR ALL HEALTH-CARE INSTITUTIONS				
WEIGHTED LEVEL OF EXPECTATIONS			SATISFACTION GAP	
EMPATHY		9.28	25.75%	74.25
RELIABILITY		9.23	28.09%	71.91
COMFORT		9.15	22.86%	77.14
DIGNITY		9.03	26.17%	73.83



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In summary, as this table shows, there is still room for improvement, with satisfaction gaps ranging from 25.75% to 42.79% out of a total possible rate of 100%.

To reach an acceptable level of 80%, the gaps range from 5.25% to 22.79%.

1.7 1997 satisfaction survey

The second survey, conducted by the Regional Board in May 1997, was designed solely to measure users' satisfaction levels. The survey, which was also conducted by *Zins Beauchesne et associés*, a member of the *Secor Group*, reached 2,000 respondents. When we analyze the results, we can see how users' satisfaction levels have changed in the context of the implementation of the first regional service organization plan, in the midst of the shift towards ambulatory care, the "*virage ambulatoire*." The results of the second survey were helpful in designing a new plan for service quality improvement. In June 1998, the Board of Directors of the *Régie régionale* adopted a second three-year plan for 1998-2002, which was designed to improve response to the needs of the population¹³ by placing the accent on accessibility and continuity of services.

1.7.1 Use of facilities – comparison between 1994 and 1997

In the three year period from 1994 to 1997, the proportion of users who visit institutions had significantly declined.

The proportion of the population who used health care and social service institutions on the Island of Montreal in relation to the general population went down from 83% in 1994 to 77% in 1997.

¹³ Régie régionale de Montréal-Centre, Plan to reorganize health and social services on the Island of Montreal, Achieving a new balance, June 1995.

Figure 13 shows the number of individuals who used a health care or social service institution during the 12 months prior to the study.

FIGURE 13 – Visits to facilities

Rate of use	1994	1997
Number of respondents who used a health care or social service institution over the past 12 months (users)	4,001	2,001
Non-users	835	635
Non-eligible users	149	109
Total population (1+2+3)	4,985	2,745
Proportion of users (1+3)/4	83.25%	76.86%
Proportion of non-users (2/4)	16.75%	23.13%

Based on these results, there were significant variations in the rates of use of hospitals, CLSCs and community groups between 1994 and 1997.

The table in Figure 14 provides detailed figures.

FIGURE 14

Category of institution	Respondents who used an institution over the previous 12 months (N=2001)			
	Rate of use		Average number of visits	
	1994 N=4001	1997 N=2001	1994	1997
Hospital (including outpatient clinic)	50.51%	59.5%	3.3	4.6
Psychiatric hospital	0.97%	1.8%	7.4	7.7
Private medical clinic	68.5%	67.5%	3.8	3.9
Psychologist or professional in private practice	8.77%	6.1%	7.1	10.0
Home visit from CLSC	3.62%	4.6%	8.8	12.8
CLSC	20.7%	29.3%	3.5	2.9
Youth centre	0.62%	0.8%	7.2	7.0
Rehabilitation centre for adults	0.77%	1.3%	17.5	18.8
With physical impairment	0.47%	1.0%	-	-
With intellectual impairment	0.07%	0.01%	-	-
With alcohol or drug abuse problem	0.13%	0.02%	-	-
Residential and long-term care centre	1.02%	1.3%	-	-
Day centre attached to a residence	0.50%	0.8%	14.1	18.6
Community group	1.50%	2.3%	10.0	22.5
Other	0.17%	0.4%	2.6	4.2

The rate of use for community groups rose between 1994 and 1997, from an average of 10 visits to 22.5 visits a year – a 125% increase.

The number of visits to psychologists and other professionals in private practice over the previous 12 months also rose, from 7.1 to 10 visits on average. Home visits from CLSCs also rose (from 8.8 visits a year in 1994 to 12.8 visits a year in 1997). The number of visits to other facilities remained relatively stable.

1.7.2 Satisfaction rates observed

Based on the average satisfaction indicator and the interpretation grid, satisfaction appears to have remained relatively stable since 1994, and is still in the "fair" zone.

Figure 15 shows how the average indicator has changed.

FIGURE 15 – Changes in average indicator

	AVERAGE INDICATOR 1994	AVERAGE INDICATOR 1997	VARIATION 1994-97
Overall	71.2	73.8	2.7
CLSCs	71.0	73.7	2.7
Hospitals	68.7	71.9	3.1

Private clinics	71.7	76.4	4.7
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Most improved expectations

If we look at the average score, few of the expectations measured have seen a really significant improvement in satisfaction. Except for the major improvement in satisfaction regarding opening hours (an increase of 19.23%), which could be attributed to having changed the question in 1997, the following expectations improved slightly between 1994 and 1997.

FIGURE 16: Six most improved expectations

Dimensions and expectation statements	
Institution is open at convenient times (weekdays, weekends and/or evenings) (ACCESSIBILITY)	19.23
Caregivers do not ask questions that have nothing to do with your problem (PRIVACY)	6.56
The institution encourages you to get support from family, friends and community groups (SOLIDARITY)	6.07
Everyone is treated equally, without any form of discrimination (DIGNITY)	5.83
There are not too many formalities in your dealings with the institution (not too complicated, not too many steps, not too much paperwork) (FACILITY)	5.77
You can make an appointment to see a professional quickly (RAPIDITY)	5.59

Expectations that deteriorated the most

One expectation in particular registered a decline in satisfaction in 1997: the flow of information between various facilities. Compared to 1994, clients said that they were much less satisfied with the continuity and flow of information between health care facilities in Montreal in 1997. Figure 17 shows the six expectations that deteriorated the most.

FIGURE 17 - Six expectations that deteriorated the most

Dimensions and expectation statements	
You feel that there is continuity and a good flow of information between various health resources in Montreal (CONTINUITY)	-13.35
The institution provides information on all the services it offers. (ACCESSIBILITY)	-4.85
The institution is easily accessible via public transit or has parking nearby (ACCESSIBILITY)	-1.73
Caregivers advise you on how to avoid a recurrence of the problem (RESPONSIBILITY)	-1.85
The same caregivers see you on each visit (CONTINUITY)	-0.08

No one makes decisions on your behalf (RESPONSIBILITY)

-0.24

1.8 Satisfaction survey of users referred by hospitals to post-discharge services at CLSCs

A satisfaction survey of target groups of users among those affected by the shift to ambulatory care enabled us to evaluate the timeliness and effectiveness of measures taken to ensure continuity of care. The SOM polling firm was mandated by the Survey and Assessment Department (Service des études et de l'évaluation)¹⁴ to conduct a study with a sampling of 350 people. The firm put together banks of users from lists provided by CLSCs.

To be entered on the list, users had to meet the following criteria:

- be 18 years of age or older;
- have been referred to the CLSC by one of the 17 general and specialized hospitals in the Montreal-Centre region;
- have been referred to the CLSC for short-term post-discharge at-home services;
- have been referred between March 1 and 31 (wave 1) or April 1 and 30 (wave 2);
- not have been referred for any problem with perinatal care, palliative care, long-term follow-up or as part of a single port of entry;
- not have been referred by a children's hospital (Sainte-Justine, Shriners or the Montreal Children's Hospital).

Questions relating to users' satisfaction were based on the regional service concept.

Figure 18 and 19 show the percentage of respondents who described themselves as "very satisfied."

FIGURE 18 – Satisfaction with preparations made at hospital

No.	QUESTIONS (DIMENSIONS)	% VERY SATISFIED
Q1.	Consideration of patient's opinion on being discharged (n=333) (DIGNITY)	57.6% ACCEPTABLE
Q2.	Explanations given in hospital on patient's state of health (n=334) (REASSURANCE)	51.3% ACCEPTABLE
Q3.	Information provided at home (what to do/not to do) (n=338) (FACILITY)	50.0% ACCEPTABLE
Q4.	Information provided on discharge re support services (n=312) (FACILITY)	51.1% ACCEPTABLE
Q5.	Contact made by hospital with CLSC (n=303) (CONTINUITY)	58.9% ACCEPTABLE
Q6.	Overall satisfaction with hospital preparations for discharge (n=342)	50.5% ACCEPTABLE

Source: SOM Inc.

¹⁴ Régie régionale de Montréal-Centre, Programming and Coordination Department (Direction de la programmation et coordination)

FIGURE 19 – Satisfaction with services provided by the CLSC

No.	QUESTIONS (DIMENSIONS)	% VERY SATISFIED
Q7.	CLSC got in touch quickly (n=335) (RAPIDITY)	73.3% EXCELLENT
Q8.	CLSC respected my opinion (n=329) (DIGNITY)	60.1% EXCELLENT
Q9.	Information on services (n=325) (ACCESSIBILITY)	59.5% ACCEPTABLE
Q10.	Respect for my choice of services (n=315) (DIGNITY)	60.2% EXCELLENT
Q11.	Respect for scheduled times (n=334) (RELIABILITY)	62.5% EXCELLENT
Q12.	Can contact caregiver at any time (n=301) (ACCESSIBILITY)	54.2% ACCEPTABLE
Q13.	Overall satisfaction with CLSC service (n=347)	63.7% EXCELLENT

Source: SOM Inc.

We can conclude from these results that users are generally satisfied with the services they receive, specifically with regards to continuity of service where links between service providers are clearly identified and spelled out in official agreements.

1.9 Focus groups

In May 1999, the Regional Board initiated a series of focus groups designed to validate the regional service concept and develop detailed content reflecting the concerns of certain specific target groups. Working with the polling firm *Léger & Léger*, the Board was able to draw up a course of action to improve satisfaction levels among the gay and lesbian communities and female victims of violence. Figure 20 summarizes the results.

FIGURE 20

QUALITY OF SERVICES FOR TARGET GROUPS		
POPULATIONS	OBJECTIVES	RECOMMENDED STEPS
Gay men	Improve response to the privacy and continuity dimensions. - Alleviate the feeling of rejection. - Help young men with the acceptance process.	- Provide consciousness-raising (additional training) for physicians on real life and culture in the gay community. - More effective distribution of information on services available. - Improve geographic outreach to set up services adapted to the community to avoid the sense of ghettoization while raising awareness in the general population. - Strengthen networks that help young men with the process of discovering and accepting their sexual orientation.
Lesbian women	Offer quality service with an emphasis on the dignity and reliability dimensions. - Break the isolation. - Alleviate the feeling of rejection. - Develop information on health issues specific to lesbian women.	- Provide consciousness-raising and training for caregivers, especially physicians, to make them more sensitive to this group. - Provide information on specific aspects of lesbian women's health (new research, level of risk for STDs, etc.) - Set up community services for lesbian women outside the gay village. - Improve communications tools to facilitate solidarity among lesbian women. - Strengthen networks that help young women with the process of discovering and accepting their sexual orientation.
Female victims of violence	Respond to the reliability dimension when providing emergency assistance and place emphasis on the dignity and empathy dimensions in the process of providing medium- and long-term support. - Create and maintain a relationship of confidence. - Improve psychological assistance so that victims regain their self-esteem. - Communicate the spirit of "personalized service."	- Provide quick access to services (psychologists, shelters, etc.). - Make consultations more available and more flexible. - Adapt choice of caregivers to specific expectations of this population (life experience, maturity, strong sense of empathy, etc.). - Promote the formation of networks for female victims of violence.

2 Improving service quality

The process of establishing regional priorities and developing regional service organization plans was based on information gathered from public hearings, users' forums, surveys of the population, focus groups, complaint reports and serious thinking by the permanent staff of the Regional Board. With the adoption of these plans by the Regional Board now has a coherent and integrated strategy for continuous improvement in service quality.

The Ministry, the Regional Board and the institutions are currently working along parallel but convergent paths to improve service. The existence of numerous activities to improve service quality is now a positive aspect in the implementation of joint strategies.

Here is a brief run-down of the major activities currently underway to improve service quality.

2.1 *Ministère de la Santé et des Services sociaux*

For a number of years, the *Ministère de la Santé et des Services sociaux* has been reviewing the tools it uses for follow-up on the operations of the network.

- Ministerial orientations promote four priorities that place the accent on the aspects most likely to pave the way for future developments in the network. The first priority is to improve service quality:
 - make client satisfaction an objective that can be assessed in the performance of institutions and service providers;
 - develop local and regional human resource development plans that place the accent on the dimensions of service quality;
 - use the information that emerges from the complaint handling process as a tool for improving service quality and the relational aspects of interventions.
- The Ministère, in conjunction with the regional boards and the institutions, is in the process of reviewing the accountability process with the intention of identifying results-based performance indicators. It plans to build specific user satisfaction elements into the performance measurement process, such as perceived competence, ease of use, speed of response, etc.
- Quality of service, user satisfaction and respect for users' rights are criteria for the attribution of the Persillier-Lachapelle Awards, which are given annually to recognize excellent work by institutions and community groups.

2.2 *Régie régionale de la santé et des services sociaux*

Since the continuous improvement programme was first set up, the Regional Board has put in place a number of tools designed to enhance user satisfaction and promote respect for users' rights.

- Through its Client Assistance Department (*Service d'aide à la clientèle*), the Regional Board has adopted a regional procedure for processing complaints, which includes the production of an integrated annual report on the processing of complaints at the first two levels, i.e. the institution and the Régie régionale.
- The Regional Board has conducted two surveys on users' expectations and satisfaction (May 1994 and May 1997).

- Through its Human Resource Development *Department* (*Service de développement des ressources humaines*), the Regional Board has organised activities for managers whose responsibilities include monitoring service quality.
- The Regional Board has supported the identification of institutional service concepts and the implementation of continuous improvement strategies in about 20 institutions that serve as pilot sites (see Part Two).
- The Regional Board has developed a variety of communications and training tools (videos, CD-ROMs and print materials) designed to:
 - make the major players aware of the need to build user satisfaction into service quality improvement strategies.
 - support managers, users' committees and caregivers in bringing programmes for continuous improvement in service quality and user satisfaction to fruition through the use of print materials, videos and CD-ROMs.

Link with regional service organization plans

When a new service or a new way of organizing existing services is designed, it is important to consider the three components of performance evaluation: **1)** user satisfaction and respect for users' rights; **2)** achieving objectives for the health and well-being of the population; and **3)** optimal use of resources.

For regional service organization plans that target specific groups or problems, strategic orientations and regional priorities that involve these three components can be built into the design of the plan.

The Regional Board includes the regional service concept and the continuous improvement process in the development of performance indicators that are now an integral part of regional planning¹⁵.

The Regional Board has adopted a regional service organization plan that includes a performance trend chart (*tableau de bord*) made up of performance indicators, including users' perception and an integrated continuous service quality improvement process.

2.3 Institutions

- More than 20 institutions have served as pilot sites for developing methods and adapting measurement tools.
- The Canadian Council on Health Services Accreditation sets standards and plays an active role in promoting service quality and user satisfaction, primarily in hospitals.
- The Conseil québécois d'agrément des établissements de santé et de services sociaux uses the service concept as a framework for analyzing the quality of client services and makes recommendations regarding continuous improvement to institutions, i.e. CLSCs, residential and long-term care centres, rehabilitation centres, youth centres, and to a lesser extent, hospitals.

Substantial investments have been made in initiatives designed to improve service quality and user satisfaction.

¹⁵ Régie régionale de la santé et des services sociaux de Montréal-Centre, *Cahier des procédures pour la production du tableau de bord*, February 1999.

3 Expanding the programme for continuous improvement

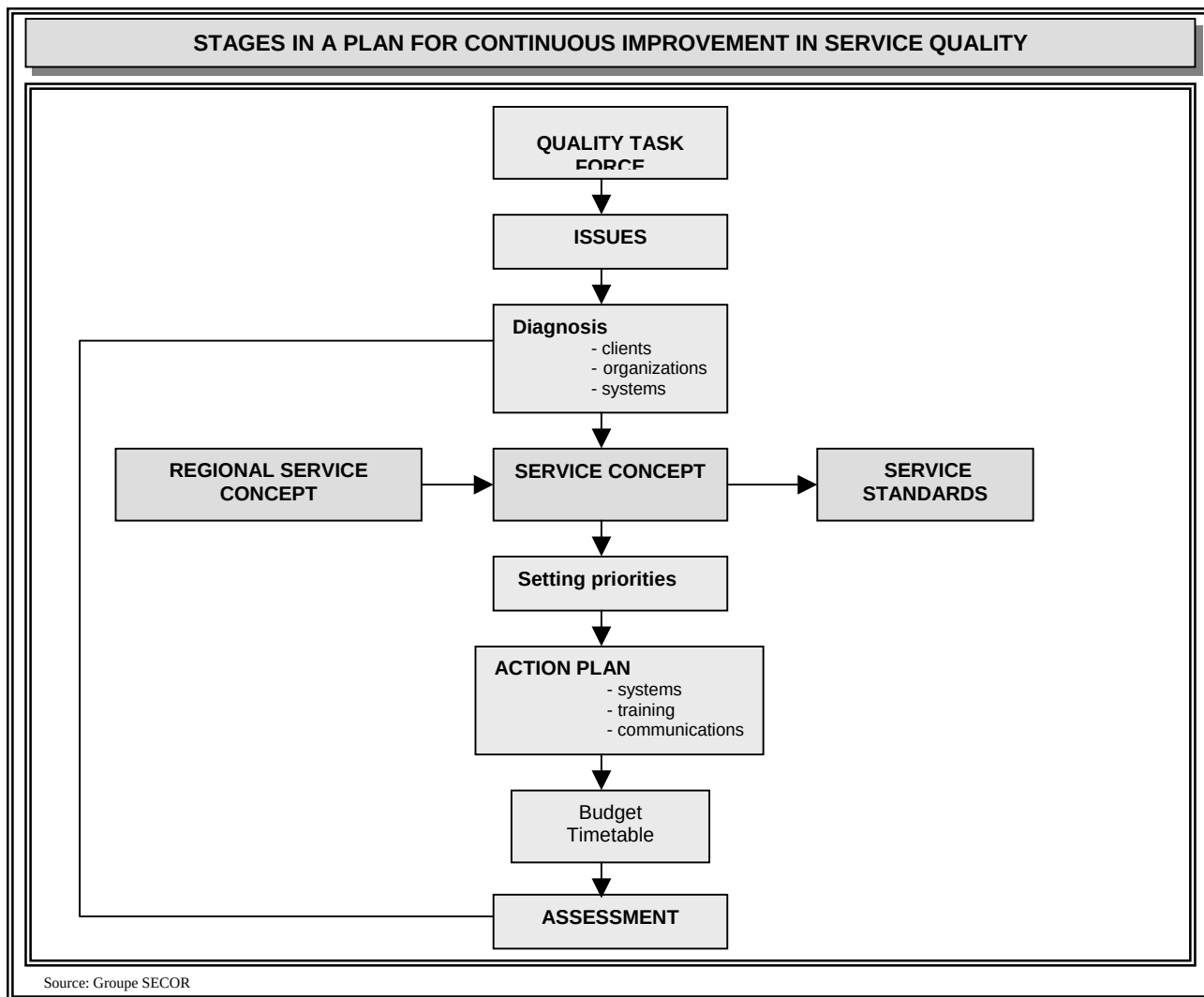
The Regional Board plans to expand the programme for continuous improvement in service quality and user satisfaction to all the institutions in the Montreal network and share the expertise acquired at various institutions that have served as pilot sites by:

- distributing the institutional service concepts developed at the pilot sites in connection with the regional service concept and related measurement tools (questionnaires);
- sharing the various approaches developed to collect opinions from the major target groups of clients in the health care and social service network, i.e. strategies, interviews, focus groups, mailings;
- sharing various strategies designed for the programme: a.) mobilizing staff, b.) communications strategies, and c.) service quality management techniques;
- adapting training in quality and user satisfaction to the current needs of decision-makers, managers and quality teams in all the institutions;
- supporting the implementation of programmes for continuous improvement in user satisfaction at all the institutions in Montreal;
- providing logistical support for the institutions by supplying them with awareness and training tools, i.e. videos and CD-ROMs.

3.1 Supporting steps taken by institutions

The Community Relations Department (*Direction des relations avec la communauté*) intends to coordinate the various departments involved at the Regional Board and support the expansion of the programme for continuous improvement in user satisfaction to every institution that wishes to implement such a process. These programmes will be required to use the regional service concept or one of the service concepts developed at the pilot sites as a reference framework, following a procedure similar to the process shown in Figure 22.

FIGURE 22



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The Regional Board intends to facilitate the initiation of service quality improvement projects in the institutions by:

- training members of boards of directors, executive directors, managers, etc. in programme management;
- supporting the formation and efficient operation of quality committees and users' committees;
- providing an analysis model for evaluating user satisfaction and processing complaints;
- supporting the assessment of progress toward achieving improvement objectives.

3.2 Supporting "quality" groups

The Regional Board will support and lead task forces of individuals in charge of implementing continuous improvement projects and facilitate the development and exchange of expertise in this area. Project leaders in the institutions that have served as pilot

sites will form the core group.

3.3 Disseminating expertise developed in improving service quality

The Regional Board plans to hold a series of information sessions for interested parties from institutions and groups, with project leaders as active participants. A regional conference will provide a forum for sharing expertise on developments in the domain of continuous service quality improvement.

3.4 Stepping up research and experimentation efforts

The Regional Board, in conjunction with partners from the Ministry, institutions, community groups and research centres, will need to provide stimulus and support for research projects and pilot projects designed to improve the monitoring process and tools/instruments for measuring and analyzing service quality and user satisfaction.

The Regional Board intends to get university research centres more involved in the continuous service quality improvement and user satisfaction process, as well as forming alliances with the private sector.

3.5 Building the continuous improvement process into services provided by the Régie régionale

It would be difficult for the Regional Board to promote something it does not itself put into application. The point is to establish a service quality improvement process in several sectors in which the Board is in direct contact with services to users.

3.6 Changing the process for institutional accountability

Generally speaking, the Regional Board should base institutional accountability on the concept of achieving results, including the three components of the evaluation process described above, as in the current "tableau de bord central" (performance trend chart). As far as possible, however, the Board should deregulate its approach, not attempt to control procedures, and act as a resource to facilitate the achievement of shared objectives.

PART 2

PILOT SITE INSTITUTIONS

4 Pilot sites

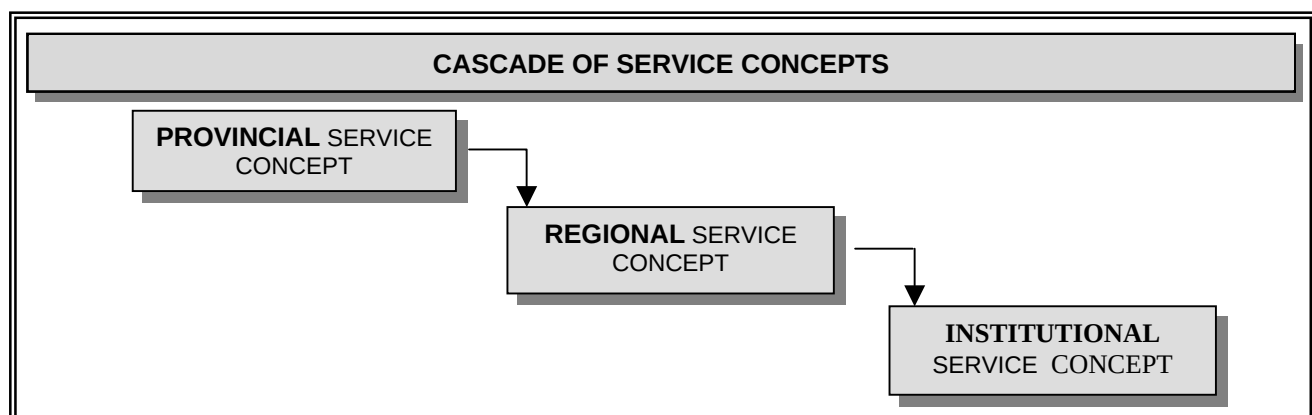
The regional service concept was defined in general terms for all services in the network - a population-based approach. The concept was not based on specific clienteles or particular category of institution other than those listed above. In response to a general appeal, more than 20 institutions served as pilot sites, helping to adapt the regional service concept to meet the expectations of specific clienteles. The various sites were to include all categories of institutions and the major target groups in the network. Each site implemented its own process for continuous improvement in service quality and user satisfaction, adapting the regional service concept in order to ask users for their opinions and develop local improvement strategies. "Quality" groups were set up on each site (in a department, ward, programme, etc.) with the necessary support, i.e. logistical and technical support and training.

4.1 *Cascade of service concepts*

The Ministry and the Government spelled out the general service concept in the Act respecting health services and social services (R.S.Q., S-5). This provided a basis and a framework for developing the regional service concept - a concept that reflects the democratic choices set forth in the legislation, the values put forward in policies and orientations, and the resources and special features of the Montreal region.

This regional service concept provides a framework and analysis model for all Regional Board activities that involve user satisfaction and respect for users' rights. The framework was used as a reference for the development of service concepts specific to the various pilot site institutions.

FIGURE 21



Source: Groupe SECOR

The Regional Board has a mandate to evaluate user satisfaction with health care and social services in the region. In the institutions where they exist, users' committees evaluate user satisfaction on the local level. The institutions have general responsibility for ensuring the quality of services to users.

The Regional Board places particular importance on a joint strategy with the Ministry, the institutions, accreditation agencies and the universities to expand the use of service concepts developed by the Board and the institutions that served as pilot sites. These service concepts will serve as the basis for setting up a coherent improvement process at all the institutions in the region.

List of institutions serving as pilot sites

After two years, twenty-two (22) institutions are now registered in the regional programme. Figure 22 lists the institutions serving as pilot sites and the different departments or programmes involved. In some cases, the entire institution served as a pilot site. The sites cover all categories of institutions and the major target groups.

FIGURE 22

PILOT SITE INSTITUTIONS		
INSTITUTION	DEPARTMENT / PROGRAMME	COMMENTS
1. McGill University Health Centre	➤ Kidney failure programme	➤ Institution currently being restructured after merger
2. Centre hospitalier de l'Université de Montréal	➤ Targets based on wards that volunteered to participate	➤ Study of all hospitalized patients ➤ Institution currently being restructured after merger
3. Hôpital Maisonneuve-Rosemont	➤ Pneumology programme	
4. Hôpital Sainte-Justine	➤ Outpatient clinics ➤ Obstetrics department	
5. Centre hospitalier Angrignon	➤ Day surgery programme	➤ Institution currently being restructured after merger
6. St. Mary's Hospital	➤ Obstetrics department	➤ Added after project was underway
7. Centre hospitalier régional de Lanaudière	➤ Emergency services	➤ Study of all patients, institution out of the region
8. Hôpital du Sacré-Cœur de Montréal	➤ Entire institution	➤ Added after project was underway
9. CLSC Rivières-des-Prairies ¹⁶	➤ Programme for children, families, youth	➤ Joint project with Mercier-Est / Anjou and Villeray CLSCs
10. CLSC Mercier-Est / Anjou ¹⁷	➤ Reception and everyday services	➤ Joint project with Rivière-des-Prairies and Villeray CLSCs
11. CLSC Villeray ¹⁸	➤ Home support services	➤ Joint project with Rivière-des-Prairies and Mercier-Est / Anjou CLSCs
12. CLSC Ahuntsic	➤ Community groups	➤ Defining service concept

¹⁶ Joint project with CLSC Mercier-Est / Anjou and CLSC Villeray

¹⁷ Joint project with CLSC Rivière-des-Prairies and CLSC Villeray

¹⁸ Joint project with CLSC Mercier-Est / Anjou and Rivière-des-Prairies

FINAL REPORT
PROGRAMME FOR CONTINUOUS IMPROVEMENT IN SERVICE QUALITY AND USER SATISFACTION

13. CLSC La Petite Patrie	➤ Entire institution	➤ Phase 2
14. Résidence Yvon-Brunet (CHSLD)	➤ Entire residence	
15. Hôpital Notre-Dame de la Merci (CHSLD)	➤ Entire institution	
16. Les Centres jeunesse de Montréal	➤ Entire institution	➤ Institution currently being restructured after merger
17. Centre Dollard-Cormier	➤ Entire institution	➤ Institution currently being restructured after merger

PILOT SITE INSTITUTIONS		
INSTITUTION	DEPARTMENT / PROGRAMME	COMMENTS
18. Douglas Hospital	➤ Adult outpatient services	➤ With participation of users' committee
19. Constance Lethbridge Rehabilitation Centre	➤ Technical support department	➤ Self-funded activities ➤ Joint project with CR Lucie-Bruneau
20. Centre de réadaptation Lucie-Bruneau	➤ Technical support department	➤ Self-funded activities ➤ Joint project with Constance Lethbridge RC
21. Centre de réadaptation Gabrielle-Major	➤ All services on CLSC territory	➤ Study of entire institution
22. Centre de réadaptation l'Intégrale	➤ Social, professional and community services	➤ Implemented by users' committee

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Summary of steps taken by institutions

A "quality" group was set up in the department chosen for the project at each institution. The groups, which consisted of managers, professionals, caregivers and users, were given a mandate to coordinate all activities for:

- evaluating user satisfaction;
- integrating other sources of information on service quality;
- identifying issues for the department and opportunities for improvement;
- setting up corrective measures;
- re-evaluating the results.

The groups identified the major issues with user participation, adapted the regional service concept to reflect local concerns, and developed techniques for reaching their specific clientele (e.g. satisfaction questionnaires, surveys with interviews conducted face-to-face, by telephone or by mail, etc.). The information gathered in the process was collated with other sources, information on complaints, reports from various councils, etc., and analyzed by the group. Based on this analysis and opportunities that arose in some cases, improvement objectives were established.

The quality committee was expected to identify steps that could be taken to achieve the improvement objectives. In some cases, these steps could be taken directly in the department.

In other cases, the nature of the problem meant that institutional decisions were required. Under the aegis of the quality committee, the steps were to be taken and institutional performance re-evaluated.

The re-evaluation process was based on performance indicators that had been agreed upon at the start, and was subject to ongoing monitoring of the results.

Each pilot site institution was thus expected to complete an entire cycle in the process of continuous improvement in service quality and user satisfaction.

Exceptions to the rule: CLSC Ahuntsic and 2^e génération

In the case of the CLSC Ahuntsic, the procedure was similar but it was necessary to define a new service concept that would reflect the concerns of local groups as CLSC clients. The quality group at the CLSC Ahuntsic included not only executives from the institution, but representatives from partners in the health care and social service network, the school system and community groups as well.

In other cases, institutions had already engaged in a continuous improvement programme for service quality and user satisfaction. This was the case for the CLSC la Petite Patrie, the Centres jeunesse de Montréal and the Hôpital du Sacré-Cœur de Montréal. For all practical purposes, they had completed the first cycle in the process without necessarily using the regional service concept. They advanced to the second cycle by making the necessary adaptations based on the regional service concept.

Mandates of "quality" teams and committees

With a mandate from their Board of Directors, the steering or quality committees or satisfaction team, depending on the term used in each institution, were in charge of implementing the entire quality strategy in the designated department or programme. They made sure that services on the ground level did improve, and if necessary, returned to key or systemic problems in the organization. Quality committees were multidisciplinary in membership.

Project leaders

The following individuals served as project leaders, oversaw the implementation of the programme, coordinated the activities of their institutional quality teams, and provided a liaison with the Régie régionale and other project leaders.

FIGURE 23

PROJECT LEADERS		
NAME	TITLE	INSTITUTION
1. Ms. Marilyn Kaplow	Director, Quality Management	McGill University Health Centre
2. Monsieur André Chandonnet	Coordonnateur	Centre hospitalier de l'Université de Montréal
3. Madame Diane Arcand	Adjointe au directeur général	Hôpital Maisonneuve-Rosemont
4. Madame Paulette Dufresne	Adjointe au directeur des relations avec la communauté	Hôpital Sainte-Justine
5. Monsieur Paul Perreault	Adjoint à la direction général	Centre hospitalier Angrignon
6. Ms. Linda Cardinal	Quality Management Analyst	St. Mary's Hospital
7. Monsieur Gilles Sabourin et	Consultant cadre à la direction	Centre hospitalier régionale de

FINAL REPORT
PROGRAMME FOR CONTINUOUS IMPROVEMENT IN SERVICE QUALITY AND USER SATISFACTION

Madame Martine Dubé	générale et Conseillère	Lanaudière
8. Madame Sylvie Doré	Responsable des communications et projets spéciaux	Centre hospitalier du Sacré-Cœur de Montréal
9. Madame Hélène Laurin	Directrice des services professionnels	CLSC Rivières des Prairies
10. Madame Chantale Perreault	Directrice des services professionnels	CLSC Mercier-Est / Anjou
11. Madame Noëlla Robert	Directrice des services professionnels	CLSC Villeray
12. Madame Micheline Moreau	Directrice des programmes et services professionnels	CLSC Ahuntsic
13. Messieurs Daniel Bilodeau and Yves Poirier	Consultant Directeur général	CLSC La Petite Patrie
14. Madame Nicole Paquin	Chargée de projet	Résidence Yvon-Brunet (CHSLD)
15. Madame Michèle Guimond	Adjointe à la direction générale	Hôpital Notre-Dame de la Merci (CHSLD)
16. Monsieur Luc Demers	Adjoint au directeur de la recherche et du développement	Les Centres jeunesse de Montréal
17. Monsieur Michel Landry	Directeur des services professionnel	Centre Dollard-Cormier
18. Monsieur Michel Perreault	Project leader	Douglas Hospital
19. Ms. Kathy LePoer Monsieur Pierre Brunet	Director of Professional Services and Director of Administrative Services	Constance Lethbridge Rehabilitation Centre
20. Monsieur Gilles Bourgault	Directeur des services professionnel et de réadaptation	Centre de réadaptation Lucie-Bruneau
21. Monsieur Michel Ladouceur	Conseiller en qualité	Centre de réadaptation Gabrielle-Major
22. Madame Renée Voisard-Corriveau	Chargée de projet	Centre de réadaptation l'Intégrale

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List of subcommittees

As required, the "quality" committees set up sub-committees or task forces to discuss specific topics:

- Task force on ethics
- Task force on clinical information
- Committees to analyze results
- Follow-up committees

Participation of users/ users' committee

Generally, at institutions where there was a users' committee, the committee participated in the user satisfaction improvement process. The participation of users, either as a committee or on an individual basis, proved to be essential to establishing the local service concept. At the CR L'Intégrale, the users' committee even initiated the project.

In other cases, such as institutions where there was no users' committee or no committee linked to the department or programme selected as the pilot site, users sat as individual members of the "quality" committees.

Presentation of user satisfaction surveys: methodology for collecting information and processing data

Based on the clientele served by the institution and activities associated with the institutional mission, the different sites used various techniques for collecting users' opinions (e.g. conducting the survey by phone, face-to-face, or by mail) and for data processing (e.g. outsourcing contract, software purchase, SEQUUS, SIIB, etc.) Figures 24 and 25 show the methods generally used to gauge users' opinions and to process the data.

FIGURE 24

Type of survey			
By interview		In writing	
Phone interviews	Face-to-face	By mail ¹⁹	Presented on-site ²⁰
Régie régionale de Montréal-Centre CHRD Centres jeunesse de Mtl CR Dollard-Cormier CR L'Intégrale CLSC Mercier-Est/Anjou CLSC Rivière-des-Prairies CLSC Villeray CR Gabrielle Major CLSC la Petite Patrie	Rés. Yvon-Brunet Hôpital Notre-Dame de la Merci CR Gabrielle-Major Douglas Hospital	CHUM CH Angrignon CLSC Ahuntsic Hôpital Sainte-Justine (obstetrics) CH Maisonneuve-Rosemont (home-care clients)	CR Lucie-Bruneau Constance Lethbridge RC St. Mary's Hospital CH Sainte-Justine (outpatient clinic) MUHC Hôpital Maisonneuve-Rosemont (ambulatory hospitalized patients)

¹⁹ To be returned by mail in postage-paid envelope.

²⁰ To be returned by mail in postage-paid envelope.

FIGURE 25

Processing methods					
Survey firm			Software		
Zins Beauchesne	Léger Léger	CROP	SEQUS	SIIB	OTHER
Régie régionale Mtl- Centre Rés. Yvon Brunet CHRD CR Lucie-Bruneau Constance Lethbridge RC CR L'Intégrale CLSC Mercier- Est/Anjou CLSC Rivière-des- Prairies CLSC Villeray	CR Gabrielle- Major CLSC La Petite Patrie	CJ de Mtl CR Dollard- Cormier	CHUM MUHC CH Mais- Rosemont CH Angrignon St. Mary's Hospital CH du Sacré- Cœur	CLSC La Petite Patrie CR L'Intégrale	St. Mary's Hospital CLSC Ahuntsic ²¹

Maintaining confidentiality in the administration of user satisfaction questionnaires

For all users, regardless of the user's problem or the category of institution involved, when the time came to fill out the questionnaires (face-to-face or in a telephone interview), the interviewer was a neutral person rather than someone associated with service provision. On questionnaires sent out by mail, the names and contact information of respondents were not shown.

In each and every case, the respondent's identity was kept strictly confidential. Clients who have been admitted to institutions for an extended periods often feel vulnerable when faced with staff members, and may fear reprisals for giving a rather negative response to questions on service quality. The assurance that respondents' identity will remain confidential increases both the number of individuals who agree to participate and the likelihood that they will give more truthful responses.

The anonymity of respondents and the neutrality of the interviewer were the two indispensable conditions for the successful measurement of user satisfaction at the pilot sites.

Importance accorded to users' responses

To encourage users to take the time to fill in the questionnaires, they had to be convinced that it was worthwhile and that their opinions would really count. Several institutions included a message from their executive directors in the introduction to the questionnaires, explaining that the institution felt that users' opinions were extremely important and how the information would be used. In addition, users were promised that concrete steps would be taken to address any cause for dissatisfaction that emerged from the questionnaires.

Sampling of respondents

To ensure the validity of the results, the sampling was based on the number of individuals served by a department or programme in a given time frame, usually one year. The more

²¹ École des Hautes Études Commerciales de Montréal and the École de service social at l'Université de Montréal

details were desired on each segment of the total population, the larger was the sampling required. In some cases, the sampling consisted of the entire patient population (e.g. at the Résidence Yvon-Brunet). In other cases, the sampling represented a percentage of users, chosen at random, who might have received services at some time over a determined period (e.g. the CHUM).

In view of the nature of their clientele, several institutions surveyed not only a sampling of users but also a sampling of users' significant others - parents and families, etc. (e.g. Centres jeunesse de Montréal, CR Gabrielle-Major).

Less autonomous patients living at residential and long-term care centres

Increasingly, those who are admitted to residential centres are less and less autonomous. Questionnaires were therefore administered to people in this category at their own pace, in view of their physical and cognitive faculties. A questionnaire with about 60 questions had to be divided into sections corresponding to the attention span of the users. Questions on a specific subject were administered in the proper context, for example, questions about the user's room were administered in the room, and so on.

When residents were unable to answer questions due to their poor physical state or diminished cognitive capacities, a significant other was asked to answer in their stead. Data from significant others were processed separately and compared to data collected directly from users.

Intellectually handicapped patients at rehabilitation centres

For the intellectually handicapped, the level of language on the questionnaire and the means of response were simplified. A helper was designated for non-verbal or illiterate users. The designated helper was not supposed to intervene directly with the user, but was expected to be able to interpret the user's answers.

As was done for users in residential and long-term care centres and their significant others, questionnaires were specifically sent to significant others of the intellectually handicapped. Data from significant others were processed separately and compared to data collected directly from users.

Adults with mental health problems at psychiatric hospitals (outpatient clinics)

For adults attending outpatient clinics at a psychiatric hospital, depending on the nature of their problem, steps were taken to ensure the validity of the data. In view of what the institution was already doing to manage user satisfaction, it was necessary to integrate the different blocks of questions previously used with these users and the Regional Board's questions. Institutional protocols were adjusted accordingly. In addition, special attention was paid to user satisfaction with the quality of information and the handling of personal problems.

Individuals with alcohol or drug-abuse problems at rehabilitation centres

For those in alcohol or drug-abuse rehabilitation programmes, the institution tried to establish a link between users' satisfaction level, how they perceived their biopsychosocial

situation to have changed, and how much of the change they attributed to interventions by the institution.

Young people with adjustment problems at youth centres

For children and their parents, the sampling had to include both those who were there on a voluntary basis and those who were not. In addition, particular attention was paid to ethno-cultural dimensions for parents born in other countries. The original institutional service concept was defined by young people in focus groups, with a few adjustments to establish the link to the regional service concept.

Community groups

The complementary role community groups play with institutions in the health and social service network and the importance to the network of emphasizing the intersectorial meshing that takes place were central to the original redefinition of the concept of users. Here, the institution considered its partners – both community groups and other institutions – to be "clients," and designed a new service concept in conjunction with the relevant authorities. The service concept was used as a base for evaluating groups' satisfaction with the institution and implementing quality improvement in relationships with these groups.

Individuals receiving CLSC services

For those who were receiving services from local community service centres (CLSCs), it was important to ensure that the sampling represented all the target programmes and services (programmes for children, families, youth, foster homes, general services, home care, etc.). Special measures were taken to protect the confidentiality of young people 14 or over who might have been receiving CLSC services without their parents' knowledge. In addition, the service concept was adapted to reflect the fact that home-care staff travel to users' homes to provide services.

The extended hours were generally well perceived by users. A higher level of satisfaction was observed in terms of facility of access to services.

Hospital patients

The majority of users reached by the pilot sites were either hospitalized patients (admitted on a regular basis or for same-day surgery, etc.) or users of emergency or outpatient services. Generally, they responded in writing to a questionnaire produced by the SEQUUS software. The improvement targets were expectations relating to rapidity of access to services. Expectations re continuity of care were targeted for improvement in a project on same-day surgery.

The hospital pilot sites harmonized the use of different blocks of questions on user satisfaction in order to manage continuous improvement in service quality. Making user satisfaction part of service quality management is nothing new for hospitals, of course. The Canadian Council on Health Services Accreditation has included that aspect as a standard since the early 1990s.

The SEQUUS software produces questionnaires from blocks of validated questions, processes

the answers and analyzes the results. The software makes it possible to include in the same questionnaire questions developed by *l'Université de Montréal* and questions taken from the Regional Board's service concept. The testing of the SEQUUS software at the pilot sites refined this tool and led to the production of an improved version, SEQUUS II, by the designer, Andromed.

Questionnaires used for satisfaction surveys

Questionnaires used by the various pilot sites to gauge the expectations and satisfaction level of users of the health and social service network are available on request from the Regional Board or the individual institution. The questionnaires were all based on the regional service concept and adapted to reflect local realities.

Summary of results

The satisfaction level of users at the various pilot sites was systematically higher than the regional average. Showing concern for user satisfaction as part of an improvement strategy appears to produce tangible results in terms of users' perception of the quality of service they receive.

Improvement activities at pilot site institutions

Figure 25 summarizes the various activities that took place at the institutions for each phase. Activities are described in detail in the individual reports for each pilot site institution.

FIGURE 25

SUMMARY: ACTIVITIES AT PILOT SITES			
PHASE	ACTIVITIES	OBJECTIVES	RESULTS
Programme implementation	• Quality committees set up. • Standing committees on satisfaction set up at pilot sites. • Recruitment of members and managers' meetings.	• <u>Quality committees:</u> Facilitate start-up and follow-up on quality improvement activities at pilot sites. Establish liaison between teams and hospital management. • <u>Satisfaction committees:</u> Facilitate expansion of programme to other departments, facilitate pooling of expertise and support at pilot sites, form groups of project leaders.	• Quality and satisfaction activities in place at 90% of pilot sites as of March 31, 1999. • Reports sent to institutions' Boards of Directors, Régie régionale and Ministère.
Staff training, information, getting everyone on board	• Training sessions for target teams. • Quality management validated as part of everyday management at pilot sites and potential institutions.	• Promote programme start-up, including satisfaction evaluation in a dynamic proactive framework in pursuit of excellence.	• Teams at pilot sites mobilized around concept of user satisfaction. • Teams at pilot sites appropriated continuous improvement programme (local service concept), measure satisfaction, performance trend chart,

FINAL REPORT
PROGRAMME FOR CONTINUOUS IMPROVEMENT IN SERVICE QUALITY AND USER SATISFACTION

			etc.
Identification of information sources	• <u>Quality committees:</u> Participation of users' committees, quality management leaders, project leaders and internal reps from CPDP, CN, clinics. • <u>Satisfaction committees:</u> Validation of regional service concept, adaptation to local needs.	• Set up analysis model to integrate all information on regional and local level. • Share information and expertise re perspective of users and significant others. • Work together to set up quality improvement activities at local level.	• Regional service concept validated. • Regional service concept adapted to local needs. • Emerging issues. • Joint efforts to target improvement priorities.
Evaluating users' satisfaction level (links to regional and local service concepts))	• Satisfaction surveys – service users and target programmes	• Provide up-to-date retrospective to orient improvement process.	• Evaluation based on both Régie régionale service concept and institutional service concept.
Information gathering and analysis	• Surveys – users and significant others • Employee surveys in some cases	• Obtain accurate appreciation of how users view services, "service dimension" aspects. • Present satisfaction/ dissatisfaction rates.	• Reports on user satisfaction produced for each site.
Identification of improvement targets	• Analysis of satisfaction level and relative importance of expectations • Integration of other information on service quality (other sources) • Identification of opportunities • Decisions on improvement targets.	• Improve clients' satisfaction level with selected targets.	• Relatively high satisfaction rate for all pilot sites.

SUMMARY: ACTIVITIES AT PILOT SITES

PHASE	ACTIVITIES	OBJECTIVES	RESULTS
Improvement activities launched at pilot sites (ward, programme, or entire institution)	• Presentation of results and decisions at all levels of pilot site institutions. • Development of improvement plan for pilot site (or institution for systemic aspects)). • Action plan launched	• Make caregivers and team leaders aware of major sources of user satisfaction/ dissatisfaction. • Improve users' satisfaction with service quality.	• Explanatory factors and improvement process analyzed at pilot sites. • Changes to services provided.
Re-evaluation of progress toward selected improvement objectives	• Results discussed by quality committees and teams at pilot sites • Performance trend charts (tableaux de bord) developed • Eventually discussed by	• Develop more targeted and effective quality improvement activities to get desired results.	• Improvement activities continued.

FINAL REPORT
PROGRAMME FOR CONTINUOUS IMPROVEMENT IN SERVICE QUALITY AND USER SATISFACTION

	steering committees, Board of Directors, etc.		
Adjustments to improvement activities	• Changes to implementation plans (needs) • Adjustment to changes in service provision	• Boost user satisfaction through targeted improvements.	• New activities developed.
Evaluation of progress toward user satisfaction improvement objectives, regionally and at pilot site institutions	• Second user satisfaction survey at pilot sites and regionally (May 1997) • Second service improvement plan at pilot sites • Second improvement plan at Régie régionale "Accent on Access"	• Provide follow-up with upper management, users and general public on programme implemented at Régie régionale and pilot site institutions.	• Satisfaction level higher than regional average at pilot site institutions • General level of satisfaction with Montreal institutions maintained (higher satisfaction re relational sector, lower re organizational sector)
Improvement programme expanded to all institutions	• Results presented to those in charge of quality evaluation and general results circulated within institutions	• Provide incentive for institutions not yet engaged in the process.	• Underway

Ronald McNeil

Problems encountered during the pilot site experiment

Two important events occurred during the trial period at the pilot sites:

- The launch of the first regional plan, "Achieving a new balance"²² and
- Early retirement for thousands of employees in the network²³

The combined effect created a sense of insecurity among staff assigned to the projects, which caused continuity problems with service quality improvement activities. While the projects were underway, several pilot site institutions experienced major changes in service provision and their organizational structure (the CLSCs, the CR Gabrielle-Major, Sainte-Justine, CH Maisonneuve-Rosemont, the Douglas Hospital, St. Mary's Hospital and Résidence Yvon-Brunet). Others were merged or integrated (the CHUM, the MUHC, les Centres jeunesse de Montréal, the CR Dollard-Cormier and the Angrignon Hospital).

Mobilizing employees at the pilot sites

Although the workers assigned to the various projects were experiencing great insecurity, the experiments in managing the quality and satisfaction teams showed that users' retrospective on the quality of services raised self-esteem for participating staff. Despite the fact that the exercise identified irritants for users, the surveys also raised some strong points in which the staff involved could take pride. Continuous service quality improvement strategies were built on this pride, creating a synergy around the pursuit of excellence. At some sites, the commitment of staff and members of the users' committees prompted reports based on a more objective (neutral) analysis of service quality.

²² Seven hospitals were closed, 7,579 employees reassigned, and \$155,600,000 reinvested.

²³ involving 5,989 salaried employees and executives.

Recommendations from the institutions

For most of the pilot site institutions, the dimensions and expectations with the lowest satisfaction levels (i.e. the highest level of dissatisfaction) were problems the institutions had attacked through local planning in some sort of restructuring or regrouping effort. The retrospective look at user satisfaction fuelled some serious thinking by decision-makers in the strategic planning process and influenced the decisions that were made. In general, although the results of the satisfaction surveys at the pilot site institutions were higher than the regional average, the same trends emerged as in the population studies conducted by the Regional Board. Weaknesses in accessibility, rapidity and continuity were found both locally and regionally.

4.2 Expanding the pilot site experiments

At most of the pilot site institutions, project activities were confined to one or two departments or programmes. Continuous improvement activities in these departments and programmes were observed by peers who hoped to find inspiration in the results achieved. The effect of limiting improvement activities and showing the positive impact in a favourable environment gave others a desire to follow this example. In several institutions, departments and programmes that were not part of the experiment decided to initiate programmes similar to those at the pilot sites. In most of the institutions, the pilot site experiment is spreading to all institutional activities, at an appropriate pace and with specific strategies for each institution.

4.3 Computer Software support, retroactive look at the users' perspective

As noted previously, several pilot site institutions used the SEQUUS²⁴ software to create questionnaires on user satisfaction, process data and produce reports on response to expectations. Software use was concentrated in the hospitals, given the nature of the blocks of questions that were available²⁵. The original version of the software did not identify the relative level of importance of users' expectations – only their degree of satisfaction.

In the process of using the SEQUUS software, a certain number of problems surfaced. The producer quickly reviewed the content of the programme and made the necessary corrections. SEQUUS II was born; while it remains a high-performance software programme for use on individual or multiple workstations, it is not suitable for interactive network use.

For a certain number of institutions outside the hospital network, the software of choice was SIIB²⁶. Like SEQUUS, this software will print user satisfaction questionnaires, process data, and produce reports on response to expectations. The SIIB software required constructing questionnaires from scratch, since the software did not include the previously validated questions. At the time, the SIIB software was available for installation on individual or

²⁴ Produced by *Theratechnologies*, a member of the *ANDROMED* group.

²⁵ Questions validated by l'Université de Montréal and the Régie régionale

²⁶ Produced by *ISO Technologie Inc.*, a member of the *TMI Technologies Multipartin'r Inc.* group.

multiple workstations; like SEQUUS, it was not adapted for interactive network use.

4.4 Recommendations made by institutions that served as pilot sites

Figure 26 summarizes some general recommendations made by institutions that served as pilot sites. Some of the recommendations address the expansion of the program, while others are specific to the management of institutional continuous improvement programmes.

FIGURE 26

PILOT SITES	
INSTITUTION	RECOMMENDATIONS
1. McGill University Health Centre	➤ That the Régie régionale take the necessary steps to support the institutions by, among other things, freeing up and allocating special funding for that purpose.
2. Centre hospitalier de l'Université de Montréal	➤ That the Régie régionale continue to support the institution in pursuing the continuous service quality improvement programme.
3. Hôpital Maisonneuve-Rosemont	➤ No specific recommendations.
4. Hôpital Sainte-Justine	➤ If the programme is to continue and more institutions are to be represented, it would be a good idea to group the institutions by category in order to further explore certain aspects of the concept of quality and exchange tools developed in the process.
5. Centre hospitalier Angrignon	➤ No specific recommendations.
6. St. Mary's Hospital	➤ Seek out individuals who have shown an interest in quality improvement. With a core group of motivated people, we could more easily achieve our objectives. ➤ Put the objectives to quality teams that go beyond the certification visit. Members of these committees must accept the fact that the teams are permanent. ➤ Provide sustained support for teams: resource people should be available to facilitate the work of committee members and provide a link to other teams. ➤ Instant access to data should be promoted. An effort should be made to build the collection of essential data into everyday tasks. ➤ Once improvement targets have been identified, it is time to spring into action and be held accountable. A follow-up process should be instituted. ➤ Results should be circulated within the programme and exchanged with the entire institution.
7. Centre hospitalier régional de Lanaudière	➤ Planning, setting of priority objectives, participatory management, establishment of pathways for improvement and optimum use of resources should be integrated into administrative units where the continuous service quality improvement model can take root. ➤ Approaches and tools should be integrated; this will make it easier to reconcile the client's interests with those of the organization.

PILOT SITES

FINAL REPORT
PROGRAMME FOR CONTINUOUS IMPROVEMENT IN SERVICE QUALITY AND USER SATISFACTION

INSTITUTION	RECOMMENDATIONS
8. CLSC Rivière-des-Prairies ²⁷	➤ The experiment should be performed with limited, homogeneous groups, and be expanded slowly within different centres of activity at institutions.
9. CLSC Mercier-Est / Anjou ²⁸	➤ Same
10. CLSC Villeray ²⁹	➤ Same
11. CLSC Ahuntsic	➤ Management should remember that establishing, maintaining or strengthening personalized contacts with partner groups is an important objective. ➤ Service agreements should be signed with major organizations. ➤ The institution and its partners should set up formal mechanisms for feedback or evaluation on their interventions, with questionnaires administered every three years. ➤ The Régie régionale should offer training on successful collaboration between organizations. ➤ Considering that referrals by the institution and groups form the foundation of relationships, an update should be made every year and specific requests from groups should be evaluated with follow-up within a prescribed period.
12. CLSC La Petite Patrie	➤ No specific recommendations.
13. Résidence Yvon-Brunet (CHSLD)	➤ No specific recommendations.
14. Hôpital Notre-Dame de la Merci (CHSLD)	➤ Promote the emergence of a culture that makes service quality and responding to users' expectations a fundamental value throughout the Quebec network.
15. Les Centres jeunesse de Montréal	➤ It would be wise to first pinpoint the conditions for successfully implementing a continuous improvement programme in the light of the experience acquired by institutions that have participated in the project. ➤ The Régie régionale should pursue coordination activities within the group and extend the programme to all institutions in the network so that there is some follow-up to this experiment.
16. Centre Dollard-Cormier	➤ No specific recommendations.
17. Douglas Hospital	➤ It would be desirable for the programme to continue as a forum for exchanges between institutions while providing assistance for the implementation of evaluation measures based on client satisfaction. ➤ More specifically: • Set up a system for dissemination and collaboration among the pilot site institutions in a specific field and other institutions in the region to facilitate the transfer of acquired knowledge. • Set up a system for further developing more specific tools. • Promote inter-institutional evaluations on a base of users to get a better picture of the clientele in the context of the restructuring of services.
18. Constance Lethbridge Rehabilitation Centre	➤ No specific recommendations.
19. Centre de réadaptation Lucie-Bruneau	➤ No specific recommendations.
20. Centre de réadaptation Gabrielle-Major	➤ Expand the project to other territories and other departments of the

²⁷ Joint project with CLSC Mercier-Est / Anjou and CLSC Villeray

²⁸ Joint project with CLSC Rivière-des-Prairies and CLSC Villeray

²⁹ Joint project with CLSC Mercier-Est / Anjou and Rivière-des-Prairies

FINAL REPORT
PROGRAMME FOR CONTINUOUS IMPROVEMENT IN SERVICE QUALITY AND USER SATISFACTION

	institution.
21. Centre de réadaptation l'Intégrale	➤ No specific recommendations.

Ronald McNeil

PART 3

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX

5 Recommendations to the Ministère de la santé et des services sociaux

In the light of the programme initiated by the Regional Board and the institutions that served as pilot sites, we believe that the health and social service network should pursue the following objectives:

- improve the health and well-being of the population;
- improve the quality of response to the expectations of the population and user satisfaction;
- improve the efficiency of services.

Such an approach would necessitate the implementation of the ministerial orientations adopted last fall. The minister's leadership in mobilizing the network in the pursuit of excellence and establishing the conditions to make this possible would involve:

- a strategy for improving the quality of response to the expectations of the population and the satisfaction of users throughout Quebec;
- accountability built into every component of the network, based on results indicators, including users' point of view;
- developing skills in human resources with an appreciation for users' opinions on services they receive and with the achievement of the desired improvements.

5.1 A mobilizing strategy for all of Quebec

The pilot site experiment demonstrated how important it is to make human resources feel valued and how easily the efforts of staff can be rallied around client's interests. Since all the major players in the network agree on the importance of the user in the system, the continuous service quality and user satisfaction improvement approach goes hand-in-hand with mobilizing staff in the network. Efforts made to achieve that end will be even more fruitful if the entire network works together in a coherent, coordinated, time-limited process.

The action plan announced by the Ministry last fall for 1998-1999 to 2000-2001, "*LES SERVICES À LA POPULATION*", and the ministerial orientations, "*NOTRE FORCE, DES PERSONNES COMPÉTENTES ET DÉVOUÉES*", paved the way for a major mobilizing effort throughout Quebec. These statements bear witness to the importance the minister and the government attach to the citizens as users of the network, and the place that is rightfully theirs at the heart of the decision-making process.

In the light of the approach taken by the Montreal-Centre region, the action plan and the ministerial orientations, concrete steps must be taken to:

- mobilize key players in the network around a common focal point: the user;
- adopt coherent service concepts at the provincial, regional and local levels;

- involve the network in mounting a better response to the needs and expectations of the population.

In the current climate of negotiations, it is crucial to take advantage of the opportunity that the signing of collective agreements would represent to make human resources in the network feel valued and launch a continuous service quality improvement process throughout Quebec.

5.2 *Built-in accountability*

The Regional Board recommends the adoption of an accountability system that would, among other things, make it possible to check users' satisfaction levels and progress towards enhanced service quality. Built-in accountability, i.e. a way of rendering accounts that includes all existing elements as well as recommended aspects, requires putting in place a single tool for presenting results on users' level of satisfaction (response to expectations). Based on their relative importance, some of these results should be included in priority performance indicators. Adopting such a system of built-in accountability would require a review of annual reports from Régies régionales and institutions, as well as information systems that specifically address users' expectations and satisfaction levels.

5.3 *Developing a computer support system*

The Ministry's desire to adopt an approach similar to the Montreal experiment throughout Quebec leads us to believe that it is important to make this easier for institutions by making available a software programme with the features of SEQUS and SIIB (described earlier), that could be used in an interactive network. Producing questionnaires on user expectations and their level of satisfaction, processing data and producing reports in a common format would provide the desired coherence throughout the province.

The Regional Board has already taken steps to have such software produced. We feel that it would be premature to proceed regionally if the ministries are considering a national approach in the near future. The Board and the pilot site institutions are offering to work together to make such a system available to the institutions by March 2000.

5.4 *Human resources: in search of excellence*

To extend the continuous improvement in service quality and user satisfaction process throughout the network, we will need to promote the pursuit of excellence and support and develop the expertise of caregivers in the network. We feel that two priorities are paramount in the framework of training efforts in this area: 1) the continuous improvement management process and 2) retrospective strategies for users and the administration of surveys on users' expectations and satisfaction level.

The training in service quality management currently provided by CFC on behalf of the Ministry could serve as a basis for this type of training if it were updated and the results of the recent experiments were added. Project leaders in the pilot site institutions have acquired

expertise in both areas mentioned above, and could contribute to updating the training program. In addition, the project leaders would be able to serve as resource people for the institutions in the implementation of their programme for continuous improvement in service quality.

5.5 A communications strategy designed to reach Quebeckers

To help the population fully understand the objectives of the reorganization of services (improvement plan for 1998-2002) and have them take ownership of the changes underway, we feel it is important for the public to receive fair, reliable and relevant information. Information should be released without media hype or partisan advertising campaigns. Among other objectives, this information should be designed to:

- stress the importance of competence and the pursuit of excellence in service provision in the network;
- establish a clear contract with the population for the network's commitment to service quality by:
 - defining and publicizing the network's commitment to meeting the expectations of the population and to achieving performance standards the public has a right to expect;
 - publicizing the rights of users and how users can assert their rights;
 - publicizing the results obtained and progress towards achieving our objectives for service quality and user satisfaction by making reliable indicators available.

Information should be personalized, easily available to the target audience, and be part of a communications plan with provincial and regional elements, as well as communications plans that are specific to the service continuums involved.

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