Orientations for the Development of Integrated Family Medical Groups and Network Clinics

Approved by the Board of Directors of
Agence de la santé et des services sociaux de Montréal
March 25, 2008

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TABLE OF CONTENTS

Page

GLOSSARY

The acronyms, terms, and titles listed below have been standardised and approved for use in this document to enhance its readability.

Agence	*Agence de la santé et des services sociaux de Montréal*
AMP	*Activités médicales particulières*
CAIS	*Couche d'Accès d'Information en Santé*
CAT	*Centre d'abandon du tabac*
CES	*Centre d'éducation pour la santé*
CH	*Centre hospitalier*
CHSLD	*Centre d'hébergement et de soins de longue durée*
CHU	*Centre hospitalier universitaire*
CLSC	*Centres locaux de services communautaires*
CMDP	*Conseil des médecins, dentistes et pharmaciens*
CR	*Clinique-réseau*
CSSS	*Centre de santé et de services sociaux*
DAMU	*Direction des affaires médicales et universitaires de l'Agence*
DI-TED	*Déficience intellectuelle et trouble envahissant du développement*
DSIE	*Demande de services interétablissements*
DRMG	*Département régional de médecine générale de Montréal*
DSP	*Direction de santé publique de l'Agence de Montréal*
ETP	*Équivalents temps plein*
FMOQ	*Fédération des médecins omnipraticiens du Québec*
GMF	*Groupe de médecine de famille*
HTA	*Hypertension artérielle*
IPM	*Index-patient maître*
INSPQ	*Institut national de santé publique du Québec*
MPOC	*Maladie pulmonaire obstructive chronique*
MSSS	*Ministère de la Santé et des Services sociaux*
OIIQ	*Ordre des infirmières et infirmiers du Québec*
PALV	*Perte d'autonomie liée au vieillissement*
PCP	*Pratiques cliniques préventives*
PTH-PTG	*Prothèse totale de la hanche- Prothèse totale du genou*
RAMQ	Régie de l'assurance maladie du Québec
RLS	*Réseau local de services*
RSIPA	*Réseau de services intégrés pour personnes âgées*
SAD	*Soutien à domicile*
SRA	*Système régional d'admission*
SRV/RV	*Sans-rendez-vous /avec rendez-vous*
TCR	*Technocentre régional*
UMF	*Unité de médecine de famille*

EXECUTIVE SUMMARY

This document presents orientations for the implementation of the Montréal model of primary care patient management. *This model calls for the development of integrated multidisciplinary teams of general practitioners and other health professionals who will manage a registered population.*

Elements of the Montréal model

There are currently 18 family medical groups (GMFs) on the island of Montréal. These medical clinics bring together physicians, nurses, clinical and administrative staff and use centralised computer technology. GMFs are committed to providing a wide variety of medical patient management services to a *registered* clientele. The presence of nursing staff in conjunction with the attending physician, allows these institutions to ensure a service offering that ranges from screening to the systematic monitoring of vulnerable clientele.

The concept of network clinics or CRs was developed by the Agence de santé et des services sociaux de Montréal (the Agence) and its Regional Department of General Medicine (DRMG). CRs are medical clinics that have accepted to play the role of coordinating and liaising with the Centre de santé et de services sociaux (CSSS) in their local service network. The development of a priority service corridor with a hospital allows CRs to make technical platforms and specialists accessible to the general practitioners from their local territory and to their patients. There are now 23 CRs in Montréal.

In order to ensure a better integration of interventions from GMFs, CRs and the CSSS general services program (which would allow us to organise services in Montréal to facilitate the management of vulnerable clientele and of the entire population), GMFs and CRs must change. The organisation we are working to build is a CR and GMF hybrid with a multidisciplinary team of health professionals — an integrated GMF and CR entity.

The integrated GMF and CR organisation model

Integrated GMFs and CRs will serve all patients managed by and registered by a family physician. Vulnerable clientele and particularly local clientele referred by a territory CSSS must be given priority. According to the long-term objective we have set, which takes into account the development of integrated GMFs and CRs, it would be possible to have each full-time equivalent (FTE)[1] physician manage 2,000[2] registered patients. The clientele will also be comprised of patients who need primary care services, be they registered or not, and who walk into the clinic without an appointment.

The service offering extends to the patients of physicians within the CSSS territory in which the integrated GMFs and CRs operate. These patients will have access to walk-in medical services, liaison services (including CSSS services, specialised services, and emergency technical platforms) and basic technical platforms, meaning basic radiology and emergency screening services.

The integrated GMF and CR medical team includes a minimum of 10 FTE physicians. The physicians work as a group with one file per patient, which will be shared with the other professionals. The other clinic professionals will be responsible for treatment processes and the administration of the clinic. They designate a head physician who coordinates the clinic schedule and operations.

The following target parameters have been set for the physicians' activities:

- 70% of physicians will carry out most of their clinical activities in the integrated GMFs and CRs.
- 70% of every physician's activities[3] will be dedicated to registered clientele.

[1] One FTE will provide 35 hours of clinical and clinical-administrative work per week.

[2] It should be noted that this is a long-term objective which will be reached progressively over time and must take into account the weighting of the patient case load and the service offering to unregistered patients.

[3] By appointment (RV), and on a walk-in (SRV) basis.

- 70% of all physicians' activities[4] will be dedicated to registered clientele within a six-month period.
- 70% of patients during this six-month period will be seen by appointment.

We suggest that a team of 15 FTE non-physician practitioners could be composed according to the following general guidelines:

- 2 nurses as liaisons[5]
- 2 to 4 nurse clinicians for patient management
- 2 to 4 nurses for the walk-in clinic (2 of these positions could be occupied by nursing assistants)
- 0.5 to 1 nutritionist
- 2 to 4 psychosocial intervention professionals (e.g., psychologists and social workers)
- other professionals to be determined (e.g., physiotherapists, occupational therapists, respiratory therapists, or kinesiologists)
- one community or local CSSS pharmacist working in co-operation with the integrated GMFs and CRs

The composition of the team will be adjusted according to the needs of integrated GMF and CR clientele and the operational methods used by the clinic professionals already in place.

Projected development

Through the advantages that this partnership will yield (e.g., access to a multidisciplinary team, computer support), the convergence of objectives and practices will lead CRs to evolve towards an integrated CR and GMF status, and will lead GMFs to evolve to an integrated GMF and CR status. Indeed, before work on this project was completed, several clinics were approached and said they would take advantage of this opportunity to apply for integrated GMF and CR status.

Once the development of approximately 60 integrated GMFs and CRs has been achieved, the primary care needs of the entire population of Montréal will be covered. Projected financing is 1.5 million dollars per entity, or a recurrent budget of 90 million dollars for the 60 integrated GMFs and CRs. Each integrated GMF and CR entity will use computerised patient files in order to record patients' clinical histories, as well as computer platforms equipped with access authorisation to a master patient record, results of tests and examinations (including radiographs); histories of patient visits, medical and clinical procedures performed, medication taken; and an assortment of other information that will facilitate the clinic in decision-making and decrease the risk of errors.

[4] By appointment (RV), and on a walk-in (SRV) basis.
[5] It should be noted that liaising activities may be performed by persons other than nurses or health care professionals.

INTRODUCTION

This document presents the principal orientations for the implementation of the Montréal primary care patient management model. This model calls for the development of multidisciplinary teams comprised of general practitioners and other health care professionals, who will manage a registered patient population.

The two first chapters of this document provide background information and discuss the project's origins. The Montréal patient management model is explained, along with the creation of Health and Social Service Centres (CSSSs) and their clinical projects. Subsequent chapters address the projected clienteles of teams; the concept of patient management in a context of integrated family medical groups (GMFs) and network clinics (CRs); the objectives, respective roles, and operating parameters of the medical team and other professionals; the trajectory of a service request; and the service offerings in clinics. Also discussed are associated technical platforms, access to projected specialised medical services, guidelines for achieving co-operation and linkages with local CSSSs (particularly those affiliated with Health Education Centres — CESs), and protocols for integrated GMFs and CRs. Some of the finer points regarding informational resources are then discussed, along with organisational and budgeting parameters pertaining to agreements to be concluded between the medical clinics, CSSSs, and the Agence de la santé et des services sociaux de Montréal (also called the "Agence"). Lastly, an evaluation framework is proposed for these organisations to verify that they have attained targeted results.

BACKGROUND

Local Community Service Centres — CLSCs

In 1971, the *Act respecting health services and social services* created our CLSCs in Québec. CLSCs were charged with the mandate of improving the health and well-being of the people who lived in their areas through a preventive, multidisciplinary, community-based initiative, focussed on promoting patient empowerment and self-management. These clinics attempted to introduce a holistic approach to medicine and to break down the compartmentalised nature of professional practice, but their attempts saw only limited success. Indeed, the initial enthusiasm and freedom of action of those early years were followed by a period in which concern for ensuring necessities like routine medical services and home care prevailed, and the medical body became somewhat tentative about its engagement with CLSCs.

Family medical groups — GMFs

In 2000, almost thirty years later, the Clair Commission reasserted the need for professional integration and the importance of a multidisciplinary approach to primary health care services. The report stated that:

> The organization of a primary care network constitutes the main foundation of the health and social services system… This network [must] be created on the basis of the current dual reality of CLSCs and physicians' offices.

In May 2001, to follow up this report, the ministère de santé et de services sociaux (MSSS) announced the creation of the family medical group (GMF) project. The implementation of the first wave of this clinical medical model began in the fall of 2002. Today, there are over 157 GMFs operating in Québec, comprising 1,570 physicians and 314 nurses, and serving 1,256,000 registered patients.

The 18 GMFs located in Montréal are medical clinics whose physicians are committed to offering a vast selection of services and medical patient management options to a *registered* clientele. Agreements with the MSSS provide for clinical (nursing) and administrative staff as well as computer-related support, proportional to their projected number of patient registrations.

Because nursing staff members work jointly with physicians in GMFs, service coverage ranges from initial patient screening to the systematic follow-up of vulnerable clienteles.

Network clinics — CRs

The concept of the network clinics was developed by the Agence and its Regional Department of General Medicine (DRMG).

There are currently 23 network clinics (CRs) in the region of Montréal. These medical clinics accept the role of coordinating and liaising with the CSSSs from their local service networks (RLSs). The development of preferential service corridors with a local hospital allows each CR to facilitate access to technical platforms and medical specialists for general practitioners from the local territory and their patients.

Since GMFs and CRs manage medical cases and CSSSs oversee the integration and coordination of services with the health and social service institutions in their respective territories, the CSSSs along with the Agence and the DRMG, are equipped to leverage improved access to medical services and to extend patient management for the population by using a clinical integration approach.

Integrated GMFs and CRs

The current challenge is to foster the development of GMFs, CRs, and the CSSS general service-program that is now underway, so that all interventions may be better integrated. The leaders who pioneered the development of our CLSCs held to the basic concept that bringing a team of general practitioners and other health professionals together in the same place is key to competent patient management for the population. This concept is now taking shape in the primary care team project. The organisation that we will be building will be a CR and GMF hybrid that incorporates a multidisciplinary team of health care professionals. We are building tomorrow's integrated GMFs and CRs.

1. Key elements in the Montréal patient management model and in the development of integrated GMFs and CRs

With the creation of CSSSs and RLSs in mind, the Agence's leaders and 12 CSSS general directors from the region of Montréal began to re-evaluate their priorities for the years ahead. In June of 2005, the re-evaluation process began in earnest, with a view to making population-based responsibilities a concrete reality. When the evaluation was complete, organising services to facilitate both the management of vulnerable clienteles and the population as a whole emerged as the overriding imperative.

Based on this imperative, four priorities were set forth:

A. Building truly multidisciplinary teams, comprised of physicians and a variety of health care professionals who will be responsible for a registered clientele
B. Continuing the formulation and implementation of the clinical project, in keeping with a populational approach, along with the hierarchal organisation of services and the application of clinical protocols
C. Developing patients' empowerment and self-management regarding factors influencing their health
D. Defining result and performance indicators for the evaluation of targets set in clinical protocols and the organisation of services

The Agence and Montréal's CSSSs are currently focusing efforts on fulfilling these four priorities.

A. Building truly multidisciplinary teams comprised of physicians and a variety of health care professionals who will be responsible for a registered clientele

Each integrated GMF and CR entity will be comprised of medical clinics that hold a dual GMF and CR status, and will enlist the services of health care professionals (such as nurses, psychologists, nutritionists, and others) to build, along with their physicians, an integrated multidisciplinary primary care team. This model of medical management will consist of both private medical services and specific public service resources from CSSSs.

Although CSSS service-program teams, medical specialists, or other resources may manage a patient case during a specific care episode, the integrated GMF and CR primary care team will still remain ultimately responsible for its patients.

B. Continuing the formulation and implementation of the clinical project, in keeping with a populational approach, along with the hierarchal organisation of services and the application of clinical protocols

The populational models for patient management that have proven the most beneficial have been founded on a rigorous management of chronic diseases and follow-up for clienteles at risk of complications, applying multidisciplinary, hierarchal clinical protocols, where required.

These protocols target specific clienteles (e.g., COPD), integrate tools such as systematic follow-up and collective prescriptions, and set out an integrated network of care and services to ensure three areas of activity: prevention, healing, and care. They also incorporate best practices and are regularly updated by teams of experts. With these priorities in mind, the Agence submitted a proposal to form a health care consortium geared towards optimising the management of chronic diseases in Montréal.

While this form of practice is primarily a clinical matter that concerns health care professionals, the adoption of these kinds of tools will be supported through the organisation of CSSS services, management agreements between the Agence and CSSS, and service contracts between the CSSSs, GMFs, CRs, and integrated GMFs and CRs, within their respective territories.

C. Developing patients' empowerment and self-management regarding factors influencing their health

The capacity of clients to manage their health care (patient self-management) is recognised as one of the most determinant factors of good health. This capacity is directly related to the level of knowledge people have about their own health, their risk factors, possible means of prevention, and how willing and able they may be to take action.

Professionals in integrated GMF and CR contexts will use recognised preventive clinical care practices (PCP), maximising educational interventions for the empowerment of patients in managing self-care as much as they possibly can. These professionals will take a proactive approach in identifying, correcting, and monitoring risk factors and at-risk behaviour patterns so as to prevent the development of chronic diseases and their complications. The Agence and the CSSSs endorse this approach and have agreed to enhance support for interventions initiated by primary care clinicians by establishing a Health Education Centre (CES) in each CSSS territory. Professionals working at this level of service will also work with (accompany) patients who want to change their lifestyle habits.

D. Defining result and performance indicators for the evaluation of result attainment in clinical protocols and in the organisation of services

Given the magnitude and complexity of the changes proposed, it is essential to define result indicators and the mechanisms to monitor progress.

The Agence's Directorate of Human Resources, Information and Planning (DRHIP) will work in concert with the Directorate of Medical and University Affairs (DAMU), the DRMG, and the CSSSs to develop a strategic dashboard that will provide a selection of indicators for gauging and improving the organisation of services. This initiative is part of the general performance measurement model developed by the Agence, which is built around four quadrants (see Appendix 1).

Over the long-term, within the framework of this model, and with the co-operation of the Department of Public Health (DSP), we should be in a position to evaluate how effective our initiatives have been in improving the health and well-being of the population — which remains our ultimate goal.

2. The CSSS clinical project and the organisation of general services

The CSSS clinical project

The CSSS clinical project has been designed to meet the population's needs regarding health and well-being in each territory by providing a variety of service delivery options. Services found in the numerous health care programs offered by institutions (e.g., general services) will be adapted to facilitate clientele care trajectories. These services include the full range of interventions involving promotion–prevention, diagnoses, treatments, follow-up, support, adaptation, rehabilitation, and palliative care.

The CSSS project takes into account the role and responsibilities of the various actors involved and invites them to work as an integrated network. It is predicated on their accountability in the provision of services to the population and in the use of the resources supplied to them. The project integrates two principles: responsibility for the population, and the hierarchal organisation of services.

More concretely, the clinical project consists in

- drawing up a needs profile regarding the health and well-being of the population in each territory and the use of local services
- analysing disparities that must be overcome to meet access, continuity, quality, and user satisfaction objectives
- selecting other models to incorporate, where applicable, in order to overcome disparities and meet selected objectives
- mobilising clinicians to participate in the organisation and management of services
- ensuring that the impact on services and the population's health are monitored

Organisation of general services

General service-program activities are currently offered in a variety of institutions. More specifically, general services

- are designed with the entire population in mind, without exception, and with no restrictions on access to services based on a patient's residency status within the reference territory[6]

[6] The only exception is the provision of in-home services. When services are provided in a client's life setting, his or her residency within the reference territory becomes a condition for access.

- address a need for the maintenance or improvement of health and well-being, or for specific problems that may be acute or reversible
- include both public health[7] activities (populational approach), and clinical and assistance activities (individual needs approach)
- are located in proximity to and are locally accessible from an institution, physician's office, or GMF

The program's *clinical* and *assistance activities* are listed below. These services are provided by The CSSSs and are analysed so that they may be matched with those in targeted medical clinics:

- nursing interventions
- diagnostic support
- nutrition
- physiotherapy/occupational therapy
- social, psychosocial, and psychological interventions
- general medical consults provided by the CSSSs (e.g., Troubled Youth program)

Apart from the activities conducted by the CSSSs, general services include primary care medical activities provided by general practitioners in private practices.

3. The integrated GMF and CR clientele and population base

Integrated GMFs and CRs will serve all patient cases currently managed and registered by family physicians. Over time, by developing collaborative efforts and sharing clinical activities with the other professionals in place, each full-time equivalent (FTE)[8] physician could undertake the management of 2,000[9] registered patients. Registering a patient will be voluntary, free, and unrestricted by territory. Vulnerable clients should be strongly encouraged to register, particularly if they have been referred by a CSSS within their territory.

The clientele who use integrated GMFs and CRs will also consist of patients with various primary care service needs, who may or may not be registered, and who may walk into a clinic and receive services without an appointment.

The provision of services will extend to the patients of physicians from the CSSS territory in which the integrated GMFs and CRs will be operating. These patients will have walk-in access to medical services, liaison services (e.g., CSSS and specialised services, and emergency technical platforms), and to a basic technical platform (i.e., basic radiology and emergency sample collection).

Section 4.8 provides a more detailed description of the integrated GMF and CR service offerings.

The table in Appendix 2 presents specific data regarding the health characteristics and the services to be used by a hypothetical patient load of 30,000.[10] These data are proportional to current use statistics in Montréal.

[7] Resource persons provide prevention and promotion activities for the clients they serve.
[8] One FTE physician would provide 35 hours/week of clinical or clinical-administrative work.
[9] Please note that this is a long-term objective. Integrated GMFs and CRs will be developed progressively over time, giving due consideration to the weighting of the patient case loads taken on and the maintenance of service offerings to unregistered patients.
[10] The number of registrations calculated for one FTE physician is 15.

4. Multidisciplinary teams — Organising patient management

This section presents the mandate parameters for integrated GMFs and CRs and their multidisciplinary teams. Their mandate is based on a concept of patient management that will develop in accordance with changes in the context, as described below.

4.1. The concept of patient management

Patient management is a trust-based professional relationship that is nurtured over time between a patient, his or her family physician, and a multidisciplinary health care team. This relationship involves several elements:

- an ongoing relationship, based on joint (patient–team) responsibility
- a broad-based biopsychosocial knowledge of the patient
- the development of a consistent care plan which includes reducing at-risk behaviour
- promoting patient self-management of various health needs through the education and support provided by integrated GMF and CR professionals
- a full range of services provided through access to various areas of expertise (medical, nursing, social, psychological, and other) and to a health care approach focussed on prevention and promotion (e.g., through check-ups)
- the coordination and integration of most treatment and health care services required by clients through clinical liaisons for referrals to other resources within the RLS or the wider health care system, as needed
- relevant information on services provided to patients outside of the integrated GMFs and CRs so that their team members can provide suitable follow-up for their patients

The attending physician will share joint responsibility with members of the multidisciplinary team for ensuring the required medical and social follow-up with registered patients. Physicians may need to arrange to be replaced by a fellow colleague or another qualified professional in order to guarantee a patient ongoing care and services.

4.2. Targeted results

In accordance with GMF and CR objectives, integrated GMFs and CRs and their health care teams will target results as follows:

- Facilitate access for every citizen to holistic patient management with a family physician through the integration of a collaborative, multidisciplinary team, prioritising vulnerable clientele.
- Provide accessible, continuous, quality medical and general services to avoid (as much as possible) redundancies, delays, and service failures, and thereby enhance the efficiency of limited health care system resources.
- Aid in the improvement of client health and in the reduction of possible risk factors through a preventive, integrated approach by making full use of screening, teaching, and prevention in co-operation with the CSSSs and the DSP.
- Use education and support to enhance patients' empowerment and self-management regarding factors influencing their health.
- Allow for enhanced clinical integration between the medical services provided by private practices and general CSSS services, CSSS service-programs, primary partner hospital services, and other health care and community partners.

- Facilitate operations as an integrated network and as a continuum of services, where appropriate, through protocols and systematic follow-up models, and through co-operation with partners.
- Maximise interdisciplinary work and support every professional in making optimal use of his or her capacities in full compliance with the laws and guidelines governing the integrated GMF and CR model, in which the physician remains the main coordinator of the service offering.
- Promote satisfaction among clients, employees, physicians, and other professionals and develop associated objectives and indicators that allow for an evaluation of the results targeted by the organisation.

4.3. The role of the multidisciplinary team

This section presents the interventions that the multidisciplinary team will undertake in order to meet the objectives of the preceding section, namely:

- act as the primary care provider with clientele, except in emergency situations requiring the technical platform of a hospital centre, or in situations in which Info-Santé is able to provide sufficient services
- fulfill most medical (diagnostic and therapeutic), nursing, psychosocial, rehabilitative, nutritional, support, follow-up and promotion–prevention needs, and make referrals to other resources when required
- receive and prioritise service requests from clientele, and promote the registration of vulnerable patients, particularly those referred by local service network CSSSs.
- establish a holistic, multidisciplinary treatment plan, if required, integrating complete biopsychosocial information, and ensuring implementation and follow-up
- assist, counsel, and guide clients through bidirectional referral mechanisms so that they can access appropriate CSSS resources (e.g., service-programs), a primary partner hospital (technical platforms and specialised services), and other primary care resources (e.g., community organisations), while remaining ultimately responsible for client follow-up
- work with professionals from the local territory and from the health care network to coordinate and systematise clientele care trajectories via clinical protocols, while respecting the hierarchal organisation of services
- inform, support, and follow up with clients to promote self-management in health problems, and refer them to CSSS Health Education Centres, as needed
- conduct scientifically recognised promotion–prevention interventions, and facilitate the reduction of at-risk lifestyle habits and risk factors
- act in a confidential capacity, in accordance with current legislation
- implement formal mechanisms for evaluating results and promoting the ongoing improvement of clinical and administrative processes

4.4. The integrated GMF and CR medical team

Composition

The integrated GMF and CR medical team will include a minimum of 10 FTE physicians. This is the required number for the implementation of the practices set out in GMF, CR, and integrated GMF and CR statutes.

Medical team operations

Every integrated network clinic will hire family physicians, who will collectively constitute the integrated GMF and CR legal entity. The physicians practising in integrated GMFs and CRs will be general practitioners who are interested in working with a medical, multidisciplinary

team, and who value medical approaches based on preventive medicine and on changing at-risk patient lifestyle habits.

Integrated GMF and CR physicians will be responsible for coordinating the service offering for registered patients. They will map out the execution of a treatment plan and, if necessary, refer clients to other integrated GMF and CR professionals, to its collaborating medical specialists, or to other resources within the health care network.

The targeted activity criteria for physicians will be as follows:

- 70% of physicians will carry out most of their clinical activities in the integrated GMFs and CRs.
- 70% of every physician's activities[11] will be dedicated to registered clientele.
- 70% of all physicians' activities[12] will be dedicated to registered clientele within a six-month period.
- 70% of patients during this six-month period will be seen by appointment.

Physicians work as a group and only one clinical record per patient will be shared with other professionals. Integrated GMF and CR physicians will be responsible for care and clinical administration processes. They will appoint a head physician to coordinate the scheduling and operation of the clinic in compliance with the parameters set out in this document.

It is understood that integrated GMFs and CRs, like other primary care medical organisations, will promote a clientele-centred approach first and foremost. This approach leaves patients free to choose the physician who treats them and allows them to maintain relations with their current attending physician.

4.5. Other integrated GMF and CR professionals

General approach

The GMF and CR multidisciplinary team of professionals (e.g., nurses, psychologists, social workers, nutritionists) will work using an innovative approach, collaborating closely with the attending physician.

Multidisciplinary team interventions will

- be focussed on team work
- be available to registered patients
- be guided, in the case of some clienteles, by multidisciplinary clinical protocols
- consider the holistic therapeutic plan mapped out by the attending physician and his or her team, with referrals to other professionals being made by the physician
- allow for various service providers to optimise their time, with a view to increasing the capacity of their integrated GMFs and CRs to register new patients
- take a preventive approach (risk factor reduction) to maximise patient education, self-management, and the maintenance of acquired self-care skills
- generally consist of short-term therapeutic activities, based on best clinical practices

While most professionals will conduct short-term interventions, the physician, nurse clinician, and, if required, other professionals acting as case managers, will conduct a longitudinal patient follow-up.

Thus, interventions made by a nutritionist, for example, will be reinforced and followed up by these other professionals. To better visualise the integrated GMF and CR concept, see the flow chart in section 4.6, illustrating an integrated GMF and CR service request trajectory.

[11] By appointment (RV), and on a walk-in (SRV) basis.
[12] By appointment (RV), and on a walk-in (SRV) basis.

Integrated GMF and CR team composition

In order to promote the holistic management of integrated GMF and CR clientele and the accessibility of family physicians, **the proportion of professionals who will work with the medical team will be one FTE professional to one FTE physician.**

A team of 15 FTE non-physician practitioners could be composed according to the following general guidelines:

- 2 nurses as liaisons[13]
- 2 to 4 nurse clinicians for patient management
- 2 to 4 nurses for the walk-in clinic (2 of these positions could be occupied by nursing assistants)
- 0.5 to 1 nutritionist
- 2 to 4 psychosocial intervention professionals (e.g., psychologists and social workers)
- other professionals to be determined (e.g., physiotherapists, occupational therapists, respiratory therapists, or kinesiologists)
- one community or local CSSS pharmacist working in co-operation with the integrated GMFs and CRs

The composition of the team will be **adjusted according to the needs of integrated GMF and CR clientele** and the operational methods used by established clinic professionals.

Role of each professional category

The respective roles and the activities of each category of professionals within the integrated GMFs and CRs are described below.

Nurses

Nurses may be assigned to three main functions within the integrated GMFs and CRs:

- the walk-in clinic
- liaison operations
- patient management (nurse clinician)

Professional activities in Nursing

Walk-in services at the clinic will include:

- pre-triage, verification of vital signs, patient preparation, physician assistance, nursing care (e.g., administering bandages or medication), diagnostic techniques (e.g., ECG or spirometry), orientation and educational interventions with patients, and initiation of a treatment plan with the multidisciplinary team or other RLS resources

Liaison services will include:

- operational connections with various CSSS services (referrals, communication of clinical data, and feedback from the attending physician) or the primary partner hospital for specialty consults and access to technical platforms (e.g., diagnostic services); functional connections with community physicians; assistance, advisory, and guidance services for clients; prospecting for partners and cultivating new connections; follow-up on co-operation agreements; and finding family physicians for vulnerable “orphan” patients

Patient management for care episodes with patients whose treatment plan is comparatively complex and/or involves modifiable risk factors will include:

[13] It should be noted that liaising activities may be performed by persons other than nurses or health care professionals.

- clinical screening, evaluation, and follow-up; initiating diagnostic and therapeutic measures; follow-up of treatment plans (compliance) and verification of self-care; advisory, counselling, promotion, and education services; affective counselling and support; and case management (service coordination and follow-up) in co-operation with the liaison nurse, the attending physician, and the rest of the multidisciplinary team

Other professional categories

Other categories of integrated GMF and CR professionals will both intervene in their field of practise and perform specific common activities, including:

- case management, according to predominant needs, to assist and orient patients regarding the various RLS resources (or other resources) when required, while providing feedback to the attending physician
- prospecting for partners in specific areas of expertise
- participating in integrated GMF and CR clinical and clinical-administrative tool design

Psychologists

Whereas family physicians diagnose mental pathologies which require medication or provide a physician's note for disability leave, psychologists provide clinical patient evaluations. They intervene to foster significant changes in patients' cognitive, emotional, or behavioural functioning, with regard to their interpersonal systems of relationships, their personality or health condition. Integrated GMF and CR psychologists will also be called upon to play an innovative role by assisting their team partners in understanding clients who engage in at-risk behaviours and in formulating intervention strategies with them to achieve short-term change in these behaviours.

Professional activities in Psychology

Integrated GMF and CR psychologists will

- detect, evaluate, and prioritise mental health problems (cognitive, affective, relational and/or behavioural)
- promote adaptation and psychological functionality in patients to enhance their well-being and autonomy
- identify, treat, and assist in managing patients exhibiting at-risk behaviour in collaboration with other members of the team
- facilitate sessions with patient groups to discuss various health care subjects (e.g., smoking cessation, stress management, or healthy food choices)

Social workers

Social workers are versatile professionals who intervene with individuals, families and groups ("collectivities" or "communities") struggling with social problems with the goal of helping their clients develop optimal skills for interacting with their environment.

Professional activities in Social Work

Integrated GMF and CR social workers will

- screen, evaluate, and identify psychosocial and relational issues in connection with patients' families and environments
- promote adaptation and improvement in social functionality to enhance patients' well-being and autonomy
- conduct interventions with individual clients and/or with those close to them to lend support, restore, or mobilise their social functionality

Nutritionists

Given the increasing prevalence of obesity, diabetes, and a number of morbid pathologies (e.g., coronary diseases, dyslipidemia, allergies, eating disorders, and undernutrition), the expertise of nutritionists will be fundamental to holistic patient management in integrated GMFs and CRs.

Professional activities in Nutrition

Integrated GMF and CR nutritionists will

- screen, evaluate, and identify problematic food choices related to patients' lifestyle habits
- conduct interventions with individuals and/or those close to them to support the promotion of healthy eating habits and to promote an optimal diet with a view to enhancing client well-being and reducing risk factors

Physiotherapists

Physiotherapists analyse the impact of injuries, diseases, or conditions on patients' range of movement and functional autonomy. Their unique contribution to integrated GMF and CR health care services will consist in re-establishing and prolonging physical autonomy and improving clients' functional capacities.

Professional activities in Physiotherapy

Integrated GMF and CR physiotherapists will

- screen, evaluate, and identify impairments, pains, functional limitations, handicaps or other current or potential physical conditions in clients, through examinations, tests, and specific measurements
- conduct interventions which incorporate approaches and techniques[14] selected to relieve pain; achieve and maintain health, physical fitness, functional autonomy, and physical performance; and educate clients on managing impairments, handicaps, and limitations associated with specific activities

Occupational therapists

Occupational therapists intervene with children, adults, or elderly persons who have physical or mental disabilities that impede their daily activities. Occupational therapists promote all forms of activity with the goal of better facilitating the functional rehabilitation, integration, or maintenance of clients within their living environments.

Professional activities in Occupational Therapy

Integrated GMF and CR occupational therapists will

- screen, evaluate, and identify functional (physical and cognitive) limitations with regard to clients' (everyday, public, domestic, and leisure) activities, analysing potential and expectations
- conduct interventions that lead clients to participate in activities that will improve their functional capacities and their skills
- help adapt a client's environment, if required, with the goal of achieving an optimal level of autonomy

Respiratory therapists

Respiratory therapists are paramedical professionals, specialised in the care of the respiratory system. They collaborate closely with physicians and other health care professionals. These therapists work principally in hospital centres, but with the advent of

[14] Techniques may include exercises, massage therapy, electrotherapy, or heat therapy.

ambulatory care and the increased incidence of respiratory diseases, they now also work in CSSSs, primary care teams, private practices, and other health care contexts.

Professional activities in Respiratory Therapy

Integrated GMF and CR respiratory therapists will

- screen, evaluate and identify respiratory issues affecting patients' everyday lifestyle habits and self care
- conduct educational interventions with individual clients and/or with those close to them to support, restore, or activate their respiratory functions, and to increase their well-being and autonomy

Kinesiologists

Kinesiologists are specialists in physical activity and can help several types of clienteles: obese persons; persons living with diabetes, coronary disease, dyslipidemia, or high blood pressure; or simply sedentary people who want to take preventive measures against disease and optimise their well-being (e.g., through stress management).

Professional activities in Kinesiology

Integrated GMF and CR kinesiologists will

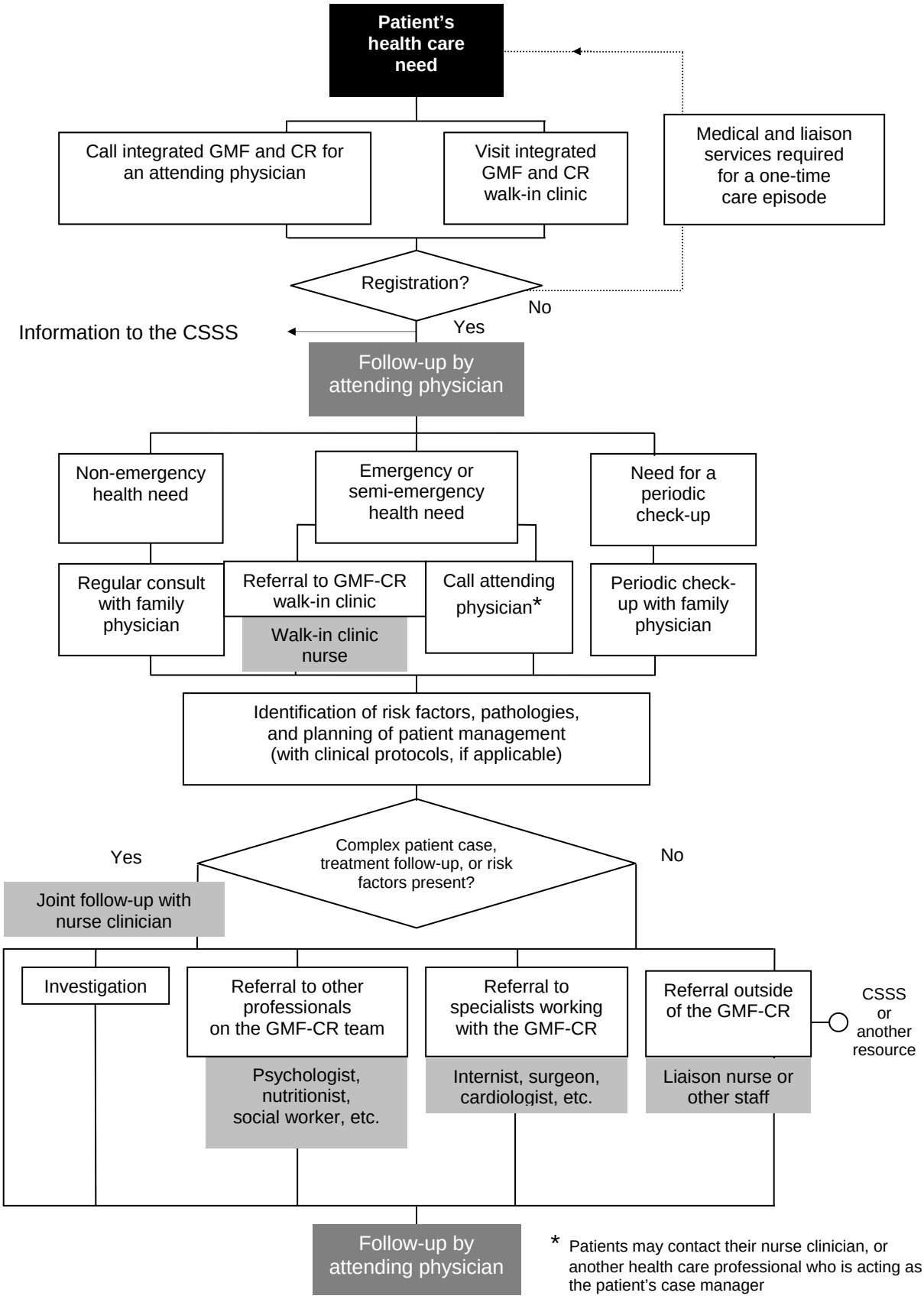
- screen, evaluate, and identify determining factors in the physical fitness and lifestyle habits of clients, analysing their potential and expectations
- provide counselling and design a program of physical activities adapted to clients' needs to improve physical capacity, assist in changing lifestyle habits, promote autonomy, and enhance holistic well-being

Pharmacists

Pharmacists are important allies for health care professionals. They can provide valuable expertise and collaborative support regarding medication (e.g., review of medication or dosage regimen). These professionals could work with the integrated GMFs and CRs in various capacities, including:

- CSSS pharmacists (service contract)
- community pharmacists (RAMQ covers pharmaceutical advice)

4.6. The integrated GMF and CR service request trajectory



Patients who are not registered with an integrated GMF or CR may use the walk-in clinic to access required medical and liaison services for a one-time care episode, which may be followed up by a one-time consult, if needed (patients may make an appointment). Patients may also inquire with the integrated GMF and CR receptionist about having their medical care managed by a general practitioner. If there is an opening, they can register with a physician, who will become their attending physician. If patients reside within the local territory, information should be sent to the CSSS, with their due consent, to facilitate the coordination and planning of services.

Registered patients who need non-emergency health care will make an appointment for a regular consult with their physician. Registered patients who have an emergency or semi-emergency health care need but who do not require hospital emergency services, have two possibilities: they may contact their regular physician, a nurse clinician, or another service provider acting as a case manager; or they can also go to an integrated GMF and CR walk-in clinic to meet with their physician or another physician (or another professional), who will have their clinical record in hand. Registered patients and their physicians may also meet for a periodic examination.

Moreover, in patient cases that are complex, that involve a number of modifiable risk factors, or in which specific treatment follow-up is required (see section 9), patients may also decide, together with their physician, to be followed by a nurse clinician (whose professional activities are presented in section 4.5). For some clienteles, patient management interventions will be guided by established clinical protocols.

During a follow-up, family physicians may direct their patients towards four types of services: internal or external investigation services, other clinic professionals who are not physicians (e.g., psychologists, nutritionists, or physiotherapists), medical specialists who work with GMFs and CRs, or any other network service available through a liaison nurse or another member of the team (e.g., towards CSSS program services, medical specialists, technical platforms, or a primary partner hospital).

A return visit to the attending family physician who has been ensuring patient case management will complete the care loop.

4.7. Multidisciplinary team operations

The attending physician will work within a multidisciplinary team, consisting of professionals from several fields of expertise. These professionals will share a common commitment to a registered clientele while providing a host of health care needs. The members of the team will be interdependent in their actions and will maintain an appropriate level of communication to guarantee an integrated and holistic response to the multiple health care needs of users and those close to them.

Collaboration between professionals

Promoting an improved spirit of collaboration between integrated GMF and CR health care team professionals will ensure better service delivery results in continuity, accessibility, and satisfaction levels among users and physicians alike. As we have shown, by working as a multidisciplinary team, we will add value to services through synergies, which will generate superior health outcomes. Health outcomes will be superior to outcomes achieved through the “usual care” and to what professionals can accomplish working in isolation from one another.

Professional collaboration will be promoted through the leadership of key people from the clinic and will involve several steps. The order in which these steps will be applied may vary, but includes

- getting to know each other

- demonstrating expertise
- trusting each other
- negotiating and coming to an understanding regarding goals
- sharing activities and responsibilities
- formalising agreements (e.g., joint follow-up protocols)
- evaluating, validating, and adjusting processes
- consolidating organisational culture and maximising a sense of belonging

By cultivating trust between clinicians, decisions can be planned and made through collaborative efforts, taking various professional perspectives into account. The integrated GMF and CR team will focus on the essential, namely, on the efficiency, continuity, quality, and accessibility of services for optimal client health.

Division of professional activities

Bearing in mind the principle of human resource efficiency and project objectives, all integrated GMF and CR professionals (physicians, nurses, and others) will ask themselves the following question: "What activities (professional or other) can I leave to others in the clinic so that I can concentrate on the task that I am uniquely qualified to perform?" In this way, it will be possible to use the full potential of recent professional legislation to maximise work organisation efficiency (see section 9, on clinical protocols).

This division of activities is part of a sharing of responsibilities that, according to the Canadian Medical Protective Association (CMPA) may be defined as follows:

> Operating within the scopes of practices established by regulatory bodies, collaborative care teams must then formally establish their own accountability arrangements. Generally, each team member remains accountable for the care he or she provides within the team model and may also be held accountable for his or her role in the team's outcomes.[15]

Subsequently, it will be important to establish job descriptions for each member of the team to eliminate task redundancy. It is vital that each member of a team know what activities the others are performing. Different forms of practice must then be allowed to emerge and innovations accepted.

The coordination of internal and external interventions

To fine-tune integrated GMF and CR team interventions, particular attention will be paid to coordination. According to the Conseil médical du Québec:

> The very essence of coordination lies in attaining a commonly held clinical objective and agreeing upon an action plan. The cohesion and linkage of care demands an investment, especially when many professionals are involved… the responsibility of delivering and coordinating primary care medical services must remain in the hands of a family physician…[16]

To structure clinical coordination various tools may be used by physicians and other professionals, such as:

- clinical protocols that address collective prescriptions
- practical clinical guides based on best practice data
- formal and informal consultation mechanisms
- reference mechanisms

[15] Canadian Medical Protective Association, *Collaborative Care: A medical liability perspective*, September 2007.
[16] Christine Beaulieu, Jeannie Haggerty, et al., *Avis sur la continuité des soins et services médicaux : La continuité, une base essentielle de la qualité* (Québec: Conseil Médical du Québec, June 2003). Our translation.

- transfer mechanisms
- multidisciplinary meetings

Professional activities will be coordinated through common logistics (e.g., telephony and computer systems), and only one clinical patient record will be kept to facilitate communications and service administration.

Formulating clear, shared objectives

The mandate objectives presented in section 4.2 will help promote greater cohesion within the health care team. These objectives focus on guiding individual behaviour to achieve common goals. The overall performance of integrated GMFs and CRs will be evaluated based on the attainment of a set of organisational objectives, expressed as administrative, clinical-administrative, and clinical result indicators. These indicators reflect quantified, targeted results that will be followed up by the integrated GMF and CR management team. A few examples are listed below:

- % of physicians' activities devoted to clinic services by appointment (target: 70%)
- % of vulnerable patient cases managed per physician (TBD)
- % of patients with a chronic disease who have been briefed (through educational interventions) about their disease and their risk factors (target: 100%)
- % of diabetic patients whose glycosylated hemoglobin (HbA1c) level is under 7% (TBD)

Management committees and management mechanisms

Providing leadership will be an essential element in the success of integrated GMFs and CRs. Their management team will therefore meet on occasion to discuss operations. Administrative (e.g., budget, computer equipment) and clinical subjects (e.g., protocols, connections with partners) will be addressed by the organisation so that results can be analysed and required administrative adjustments can be made to ensure ongoing improvement. To this end, planning for and developing appropriate administrative, clinical and personnel management mechanisms will be essential.

4.8. The integrated GMF and CR service offering

The integrated GMF and CR service offering is presented below, in two operational categories:

Services for all clientele, including patients of physicians from the community

- basic medical services provided on a walk-in basis, including a one-time follow-up consult for a care episode (arranged by appointment, as required)
- liaison services (e.g., CSSS services, specialised services, and emergency technical platforms)
- assistance for vulnerable orphan clientele in finding an attending physician
- emergency sample collection and basic radiology tests (Appendix 3)
- medical services for immediate action in case of emergency (e.g., ECG or IV fluid)

Services for registered clientele, in addition to those listed above

- basic medical services provided by appointment
- preventive clinical practices recognised through best clinical practice outcomes, notably those from the Collège des médecins du Québec
- access to consults in psychology, social services, nutrition, physiotherapy, and other areas, in coordination with a physician and according to local realities

- follow-up in nursing care (including screening, evaluation, and clinical monitoring, compliance and verification of self-care, advisory services, promotion and education, counselling and affective support, case management), coordinated with the physician
- promotion, information, and health education services[17] in co-operation with the CES of the CSSS
- 24/7 on-call medical/nursing services (including house calls) for fragilised clienteles identified by integrated GMF and CR physicians, working in co-operation with CSSS Home Care services (SAD) and Info-Santé nursing and medical services
- Integrated GMF and CR medical team in-home maintenance services (including house calls) provided to the patients the team has registered for SAD, in co-operation with the CSSS
- vaccination within the framework of the public health care program in cases of pandemics or epidemics, in co-operation with the CSSS
- routine vaccination (optional) in co-operation with the CSSS
- obstetric care (optional)

Integrated GMF and CR services will be adjusted to achieve complementarity with those offered by the local territory CSSS and will be explicitly set out in an agreement between the two parties.

5. Technical platforms and diagnostic services

Three main areas of access to technical platforms and diagnostic services will be provided for integrated GMF and CR clients and for the patients of general practitioners from the local territory.

Basic radiology services

Ensuring rapid access to basic radiological examinations on site or in proximity to integrated GMFs and CRs is an essential criterion for accreditation.[18] This service will be available at least 6 days a week, 6 hours a day on weekdays, and 4 hours a day on weekends and statutory holidays. Basic radiology services are described more fully in Appendix 3.

Emergency and semi-emergency services

Emergency sample collection services will be available at integrated GMFs and CRs so that patients have access to the full range of services they require (see Appendix 3). Emergency medical imagery, like emergency ultrasounds or tomographies, will be accessible on a daily basis through a hospital within the integrated GMF and CR service corridor (at a CSSS or primary partner hospital). Test results will be accessible within two hours (or the next day, if a request is made at the end of the day).

Emergency equipment

Owing to the wide array of clinical courses that will be presented at integrated GMFs and CRs, staff will be ready to provide emergency interventions. Thus, integrated GMFs and CRs will have equipment at their disposal such as ECGs, defibrillators, oxygen, and IV apparatus.

[17] Integrated GMF and CR interventions should facilitate team interventions in specific areas of practice, notably for persons living with chronic disease.

[18] To avoid any possible confusion, we have set out a 100-metre parameter, within which medical imaging services are considered to be "in proximity" to integrated GMFs and CRs. If this service is not initially available, it is deemed improbable that it will become available.

All technical platform and diagnostic services will be provided at integrated GMFs and CRs, regardless of a referred patient's territory of residence. Bidirectional communication support mechanisms will be in place.

6. Access to consults and specialised medical services

Whether medical specialists provide diagnostic or therapeutic expertise, offer the possibility of joint follow-ups, or simply make themselves available to manage a patient case during a care episode, these professionals will help make family physicians at integrated GMFs and CRs more effective in their practice. Accessibility to medical specialists in integrated GMFs and CRs will be maintained in two ways.

First, integrated GMFs and CRs will ensure the co-operative efforts of a core group of medical specialists on site (e.g., cardiologists, general surgeons, internists). If necessary, integrated GMFs and CRs may enlist the services of other specialists. Most services will be provided by appointment.

Second, in accordance with their status, integrated GMFs and CRs, in co-operation with the Agence and DAMU, the CSSSs and regional hospitals, will ensure organised access to specialty consultations (establishing service corridors) for all of the general practitioners in their community. These service corridors will be made available to all patients, whatever their territory of residence.

7. Guidelines for co-operation and linkages with CSSS service-programs

While patients managed by integrated GMFs and CRs will get most of their health care services through their clinic, on occasion some conditions may require CSSS resources (e.g., the Physical Impairment or Mental Health service-programs). To establish an obstacle-free patient care trajectory through the network and its institutions, integrated GMFs and CRs will set out linkage guidelines that ensure an ongoing bidirectional flow of information with a CSSS, using simple, user-friendly mechanisms. The computerisation of such linkages will not only aid in cultivating trust between the people involved in both organisations, but will also enhance the co-operation that is required to achieve objectives in continuity of care.

Access to CSSS services

Access mechanisms for the various CSSS service-programs will help to direct patients towards the right service providers and the right services as quickly as possible. It will be important not to redo evaluations that have already been done by integrated GMF and CR professionals, but instead to base evaluations on the body of data previously provided by the patient. Hence, the CSSS and integrated GMFs and CRs will agree on guidelines for referral and patient management, and include them in their service agreement.

To properly guide clienteles according to their conditions, integrated GMF and CR members will possess contact information for the CSSS services (e.g., for blood sample collection) that are not available at integrated GMFs and CRs. To this end, integrated GMF and CR staff members may send an Inter-Institution Service Request (IISR) to their CSSS (see the **Forms and Tools**, further in this section). Three such programs and services will be discussed here in greater detail: *General, Mental Health, and Home Care* services.

General services

Since the general service-program will be reorganised under this project, the CSSS service offering and that of the integrated GMFs and CRs in their territory will both have to make some adjustments to achieve complementarity. Adjustments will be made according to local realities and with a view to achieving economies of scale. For example, some services may be provided either at a CSSS or at integrated GMFs and CRs (e.g., vaccinations).

CSSS psychosocial services (interventions conducted by a social worker or a psychologist), will complement not only those offered by the integrated GMF and CR team, but also those offered through the CSSS mental health program.

Mental Health

Mental health care services are undergoing a major reorganisation in the region of Montréal. In accordance with the MSSS 2005–2010 Mental Health Action Plan, "Strength in connections," primary care mental health teams for adults and young people are being created in each CSSS.

CSSS mental health teams will be an integral part of their local network and decidedly interdisciplinary in nature, comprised of physicians (psychiatrists and general practitioners), psychologists, social workers, nurses, and other professionals, according to the profiles and the needs of the clienteles to be served. The mandate of these primary care mental health teams includes

- intake and evaluation of patients
- treatment, in co-operation with other primary care professionals[19]
- orientation, referral, and liaison services for clientele (e.g., for secondary care services)
- expertise-advisory services for other professionals and network physicians
- training, prevention, and mental health promotion activities

The teams will take a co-operative approach so that their activities dovetail with those offered through general psychosocial services, CSSS family-child-youth services, and specialised secondary and tertiary care services. In co-operation with primary care professionals from their territory (e.g., GMFs, CRs, integrated GMFs and CRs, and medical practice physicians, and CSSS psychosocial service providers), mental health teams will focus on primary care patient management for the majority of persons living with moderate or stabilised severe mental health disorders.

Each CSSS will work towards developing a single port of entry to mental health care to facilitate service request trajectories.

Home Care

CSSS Home Care services (SAD) will receive patient referrals from integrated GMF and CRs.[20] On occasion, integrated GMF and CR clients will be referred to short-term services (a care episode following hospital discharge) or to other more long-term services (for persons experiencing a loss of autonomy associated with ageing or another cause). Throughout this referral, an integrated GMF or CR physician will remain the attending physician for his or her patient.

Integrated GMF and CR staff members will familiarise themselves with the specialised geriatric and rehabilitation services that are available within the territory of the clinic (e.g., day hospital).

Other clienteles

Other agreements could be concluded between CSSSs and integrated GMFs and CRs regarding the various clienteles served by both organisations in connection with CSSS service-programs: Troubled Youth, Addiction, Loss of Autonomy Associated with Ageing, Physical Health, Physical Impairment, Intellectual Impairment and Pervasive Development Disorders (DI-TED), and Public Health.

[19] Taking on the medium- or long-term follow-up of a number of patients by the primary care mental health teams will reduce accessibility to this team for new patients.

[20] Home Care services are offered to integrated GMF and CR patients through their local territory CSSS.

Forms and tools

To optimise interface navigation between services and institutions, the Agence has developed a bidirectional information exchange tool, designed for inter- and intra-institution service requests (IISRs). This referral tool is being deployed in Montréal, and is currently used by over 110 institutions (all hospital centres, including psychiatric hospitals; all CLSCs; all rehabilitation institutions; several CHSLDs; and some CRs). The IISR uses the network's existing social service telecommunications system through a Lotus Notes application that integrates into the Master Patient Record (IPM) and the I-CLSC.

The main document in the IISR contains the origin of the request, user ID, the nature of the request, physician ID, necessary clinical information, and patient consent regarding the transfer of his or her information. Some forms may be attached (e.g., a COPD follow-up or a user autonomy summary) and a receiving service provider may send an intervention follow-up back to the institution of origin.

Producing a CSSS local service directory

Some CSSSs have taken the initiative of establishing their own exhaustive service directories, in the form of folders and booklets containing a wealth of local information, such as

- the names of services and their mandates
- target clienteles
- hours of operation and contact information
- details and directives (e.g., CLSCs do not supply medicated ointments)

GMFs, CRs, integrated GMFs and CRs, and other points of service within the territory would greatly benefit from this kind of resource, particularly within the framework of the integrated GMF and CR project.

Répertoire des ressources

The *Répertoire des ressources,* contained in Lotus Notes software, is a networked, province-wide tool which has existed since 1997. It is a provincial directory of community resources that is updated on an ongoing basis.

In addition to assisting service providers working for the Info-Santé phone service, it may be a useful tool for all managers, professionals, and network service providers who wish to inform and orient clients regarding current social service and health care resources. The integrated GMF and CR staff will have access to this data base.

The *Répertoire* includes

- listings for a variety of resources
- available services and their target clienteles
- contact information and hours of operation for organisations

This document is currently available in French only.

Prioritisation and waiting lists

The mechanisms to prioritise access to various CSSS service programs will be determined by the relevant teams and provided to integrated GMF and CR staff. This matter should be decided between the integrated GMFs and CRs and their CSSS, and form part of their agreement.

Local DRMG tables

The local DRMG tables are mandated to develop operational connections between primary care medical services and health care network professionals (e.g., regarding technical platforms and specialised medical services). The objective of local tables is to facilitate functionality between these two entities so that they operate as a local network, backed by communications tools such as

computerisation. These medical bodies are the ideal contexts in which to discuss linkages between primary medical care and other territory health care services.

8. Guidelines for co-operation with Health Education Centres — CESs

The Agence and the DSP, in co-operation with the Montréal CSSSs, decided to establish Health Education Centres (CESs) in each local territory to bring several promotion and prevention activities together under the same roof, thereby optimising initiatives to provide the population with health care information on healthy lifestyle choices.

CES objectives

CESs have four main objectives:

A. Providing individual or group educational activities to clientele referred by primary care professionals and to members of the population in the territory who express a need to obtain support to change their lifestyle habits
B. Increasing awareness about local resources or about resources outside of the territory to support clients in their initiatives to change their behaviour
C. Providing referrals, as needed, to clientele for other CSSS services or for local territory community services (e.g., Diabetes education centre or a walking club).
D. Helping to promote healthy lifestyle habits among CSSS staff

CES clientele

Primary care professionals will refer clientele. More specifically, physicians, nurses, and other service providers at CRs, GMFs, private clinics, and CLSCs will identify clients who are likely to benefit from CES health education services.

CES staff

The core staff at a CES will consist of

- one health care educator, responsible for organising educational activities on diet, physical activity, and smoking
- one service provider from the Smoking Cessation Centre (CAT), responsible for intensive intervention in smoking cessation
- one CSSS nurse responsible for clinical prevention services

As part of the deployment of preventive clinical practices in Montréal, CSSS nurses responsible for clinical prevention will participate in developing and operating CESs. These nurses will promote preventive clinical practices for healthy lifestyle habits in primary care contexts by liaising between clinics and their CES.

CES Services

During the first phase of deployment, CES interventions will cover three areas of health education:

- smoking cessation
- healthy eating
- regular physical activities

During the second phase of deployment, the service offering will be expanded to other preventive clinical practices.

Services from integrated GMFs and CRs and services from CESs should be complementary. The role of the CSSS nurse responsible for clinical prevention services will include ensuring harmonious relations between local integrated GMFs and CRs and their CES.

9. Integrated GMF and CR clinical protocols: development, implementation, and follow-up

Background

Some patients, such as those who are living with a chronic disease or other pathologies, present with complex health and social service needs. Their service needs may require interventions from a variety of service providers (e.g., physicians, nurses, pharmacists, nutritionists, physiotherapist, social workers, and psychologists), who may work in several different health care institutions. The clinical integration of services for these clienteles has proved to be the best way to improve service continuity, patient satisfaction, and health care system efficiency.

In keeping with this approach to efficiency, Bill 90 was introduced to amend existing legislation dealing with professional collaboration. Because of this policy shift, the former "delegation of acts" concept has now been replaced by a new impetus to find "shareable activities," to optimise potentially collaborative areas of practice. Professional engagement in shareable activities is conditional on receiving adequate training and on the issuance of a physician's order.

Several GMFs in Québec have already developed clinical protocols that take a more multidisciplinary approach to serving different clienteles. These tools will be compatible with integrated GMF and CR practices and constitute a new form of collaboration between physicians and other professionals.

The Agence, in co-operation with the CSSS, will develop clinical protocols based on best practices for target clienteles whose cases will be managed within the Montréal health care network, and more specifically by integrated GMFs and CRs. To provide support to the CSSSs in this aspect of their clinical project, the Agence has associated itself with Groupe de recherche en gestion thérapeutique to create the Consortium montréalais en gestion des maladies chroniques.

The Consortium's work will be based on the six characteristics of the Chronic Care Model developed by Dr. Ed Wagner, Director of the Improving Chronic Illness Care program:[21]

- supporting patients to help them manage their own treatment and health
- promoting interdisciplinary practice within health care teams
- fostering concerted team work and coherency between primary and secondary care
- providing tools to assist with decision-making (practical guides and access to consultants)
- maintaining an information system that links registry and clinical follow-up functions
- participating in community resources to meet patient needs

Several specialised, multidisciplinary health care teams (e.g., those working with diabetes, heart failure, and COPDs) are already operational within the Montréal health care network. Integrated GMF and CR teams will benefit from working collaboratively with these resources.

Agreements between integrated GMFs and CRs and CSSSs will facilitate collaborative efforts to develop, implement, and follow up clinical protocols. CSSSs, their councils of physicians, dentists and pharmacists (CPDP), and their nurses' directorates will support the integrated GMFs and CRs in this area.

Integrated GMF and CR clinical protocols

Integrated GMF and CR clinical protocols will call for a systematic follow-up of clientele and the use of collective prescriptions. The purpose of these protocols will be to facilitate patient care

[21] Improving Chronic Illness Care is a US-wide program run by the Robert Wood Johnson Foundation, an organisation dedicated to the idea that the health care system in the United States can do better, particularly with regard to the management of patients living with chronic conditions such as diabetes or depression.

trajectories within the network and to provide recommendations for professionals (family physicians, nurse clinicians, and other professionals) regarding the prevention, screening, diagnosis, and patient management of specific health problems. Recommended interventions will be based on clinical best practices and will be regularly updated by teams of experts.

Protocols and the courses of action they suggest will be subject to the clinical judgement of professionals, the preferences of patients and those close to them, and the availability of resources. The members of the Commission mulitidisciplinaire régionale (CMUR) therefore recommend that each professional, based on his or her clinical expertise, takes into account best practice data, context of the request, particular characteristics of the client and of his or her values.

Integrated GMF and CR protocols will address cases that are

- generally frequent and complex
- involve several types of professionals who will work as a multidisciplinary team
- relevant to various primary and secondary care providers and organisations
- often the cause of trips to emergency wards, hospitalisations, or residential placement
- deemed by professionals and managers in the field to be priorities

Integrated GMF and CR protocol content includes

- target goals and objectives
- identification criteria or indications regarding clienteles targeted by the protocols
- contraindications vis-à-vis protocol application
- holistic patient management activities, including education-oriented interventions
- various contributing partners
- the division of activities
- coordination and communication mechanisms, including referral, transfer, and follow-up guidelines
- collective prescription(s)
- a list of reference documents and a bibliography
- result indicators and evaluation guidelines

Collective prescriptions

Clinical protocols are subject to the *Regulation respecting the standards relating to prescriptions made by a physician*, set out by the Collège des médecins du Québec, in which the protocol is defined as “the description of procedures, methods, limits or standards applicable for a specific condition in an institution” (Division 1.2(3)) According to this regulation, a protocol is always governed by either an individual or collective prescription, which provides the basis for further action regarding the protocol.

Collective prescriptions can improve the organisation of team work. After an initial consultation with the physician, he or she may issue a collective prescription. Dispensed by one or several physicians, collective prescriptions allow one person or a group of entitled persons (e.g., nurses), to engage in specific activities without having to obtain an individual prescription from a physician.

Therefore, the target patient for this prescription need not been seen by the prescribing physician every time he or she comes to an integrated GMF and CR entity. Collective prescriptions are indispensable tools for the roles that nurse clinicians are called upon to fulfill within the GMF model and the integrated GMF and CR model.

In specified clinical situations, collective prescriptions allow service providers to

- undertake diagnostic or therapeutic measures
- conduct examinations or tests

- carry out or adjust treatments
- initiate or adjust drug therapy

Collective prescriptions, whose mandatory content is found in Appendix 4, also specify the circumstances in which medication, treatment, or examinations may be prescribed, and list possible contraindications. To guide physicians and nurses in the formulation of collective prescriptions, an OIIQ/FGPQ[22] work group has recommended that specific guidelines be followed. In sum:

- An attending physician should be designated for each collective prescription dispensed.
- Training should be organised for nurses, as required.
- The frequency of the intervention should allow for the maintenance of the competency of the persons called upon to fill the collective prescription.
- The collective prescription should comply with available scientific data, and a regular content review should be planned for quality assurance.

Although the Association québécoise d'établissements de santé et de services sociaux recommends that collective prescriptions from a GMF or from an integrated GMF and CR situated outside of an institution be submitted to a local territory CSSS council of physicians, dentists, and pharmacists (CMDP), it is not mandatory to do so. The designated physician, who is responsible for drafting the collective prescription, will also be responsible for its scientific content. Moreover, the OIIQ/FGPQ work group recommends that collective prescriptions be approved by the director of nursing overseeing the dispensing nurses so that he or she may ensure their competency.

10. Informational resources

A computer needs assessment was conducted by the Agence's Regional Technocentre (TCR) regarding the implementation of the Montréal model of patient management and the creation of integrated GMFs and CRs. The goal is to make integrated GMFs and CRs as multidisciplinary, integrated, and paper-free as possible. Once installed, the various computerised components will greatly facilitate the evaluation and piloting of health care system processes. At the same time, clinical computerisation will foster information exchanges and an interdisciplinary approach.

Having evolved from basic data storage to highly interactive functions, clinical computer systems can now equip physicians and other professionals with indispensable tools: assistance with prescriptions, recommendations regarding clinical practice guidelines, documentation and planning of care and services, an alert and call-back system, automatic notification of lab results, and more.

The Commission infirmière régionale de Montréal (CIR) recommends that we ensure that integrated GMF and CR nurses have at their disposal the following computer tools:

- Info-Santé protocols (including systematic updates of the *Bottin des ressources*)
- AQESSS nursing methods (including updates)
- Québec Immunization Protocol
- Tools for the therapeutic nursing plan

The TCR needs assessment determined that these kinds of software programs should be installed in each integrated GMF and CR to facilitate patient management by service providers. Integrated GMF and CR computer platforms will provide access to a master patient record, results of tests and examinations (including radiographs); histories of patient visits, medical and clinical procedures performed, medication taken; and an assortment of other information that will facilitate the clinic in decision-making and decrease the risk of errors.

[22] OIIQ and FGPQ, *Rapport du Groupe de travail OIIQ/FMOQ sur les rôles de l'infirmière et du médecin omnipraticien de 1re ligne et les activités partageables* (Montréal: Ordre des infirmières et infirmiers du Québec, Federation of General Practitioners of Québec, October 2005)

Beyond implementing specialised applications, we must guarantee users that their confidential data will only be made accessible to other service providers if they have given their due consent. To this end, patient records should be established in a simple environment and consent management mechanisms will be straight forward.

The general architecture of the system relies on a “per service” approach and all of the tools comprising a master patient record will eventually be integrated through the Health Information Access Layer (CAIS), in an HL7 format. Systems for integrated GMFs and CRs would include components for a master patient record and a computerised patient file record, appointment and invoicing systems, a laboratory and medical imaging request/results module, a prescriber/advisor function, and a pharmacological profile. This equipment will also allow for the scanning of data and files. Moreover, a link for an Internet connection will be provided for access to email services and access to online subscriptions to specialised reviews. Needs regarding the use of and connection to products such as the Integrated Service Network for Elderly Persons (RSIPA), IISR, and I-CLSC with the aforementioned systems have yet to be determined.

Master Patient Record

A Master Patient Record (IPM) for the registration of integrated GMF and CR clients will be installed on the various work stations to interface with admissions-discharge-and-transfer (ADT) systems. Therefore, from the time a user from the territory is registered with integrated GMFs and CRs, the IPM will record his or her registration in the CSSS systems.

Ideally, the IPM system should have the possibility of creating additional information fields for inputting new data (e.g., consent information).

Appointments

The appointment module is a tool for making, following up, and managing patient appointments. When this module is integrated into the other modules in integrated GMFs and CRs, it will display the daily, weekly, or monthly schedules of physicians and other professionals, and may be used to conduct searches using a number of parameters.

Billing

A billing module will be available for computerising physicians’ RAMQ bills. The basic data for invoicing will come from the computerised patient record module and allows for the correction of data before they are sent to the RAMQ for processing.

Computerised patient record

The computerised patient record is an essential tool for recording patients’ clinical histories. It provides access to data regarding the various clinical care episodes to improve decision-making and patient management among health and social service professionals. It also allows for administrations to optimise resource use and service quality. Computerised patient records can help to decrease and prevent incidents, and can enhance our understanding of problems related to human pathologies over the long term.

More and more, computerised patient records are being used as proactive tools in the daily duties of health care professionals. They integrate harmoniously into clinical processes to promote optimisation and simplification. They also establish a cognitive space for co-operation between users, and between users and the computer system itself, thus reinforcing their respective strengths and potential.

The patient record will include any information that health care professionals will require in the course of their practice: appointments, patients waiting, test results, and space for clinical notes from various professionals, all in a confidential format that is exclusively accessible to authorised users.

The system will also provide for the possibility of retrieving and warehousing encoded clinical information with the goal of generating analyses and disseminating specific patient notices, such as reminders regarding vaccinations or follow-up examinations.

Computerised patient records may also be used to establish, apply, and follow up the clinical protocols that will be defined for integrated GMFs and CRs, as indicated in section 9 in this document. In this way, electronic clinical protocols will bring theoretical knowledge to bear in the daily realities experienced by work teams, while facilitating close clinical monitoring for patients. This option will also generate result indicator data in the application of protocols.

Request/Result module

This module allows for the management of requests, lab analysis results, and medical imaging information. An Inbox that indicates whether results have been viewed can display test and examination results, which will then be filed in the computerised patient record.

This module makes it possible to consult available scanned medical imaging data by accessing existing specialised data banks. The goal is to build a centralised file containing images or videos relevant to the diagnostic follow-up of patients. The visualisation of laboratory results and images from the Picture Archiving and Communication System (PACS) will be supported and allow requests to be sent to different systems. It will also offer archiving and communication functions.

Prescriber

This module allows for the simplification of the electronic prescription management process and facilitates communications with various service providers. It contains a pharmacological advisor, pharmacological patient profiles, and tools for assistance in decision-making. Thus, it can aids physicians in finding the best possible solutions and in better managing risks such as drug interactions and allergies. The Prescriber module will be connected to RAMQ data bases and to a hospital pharmacy system, as required.

Scanning data

Patient (paper) files are often enormous and clinics constantly find themselves forced to expand archive rooms to keep pace with growing needs. By scanning files, organisations can not only count on gaining some space, but also on improving their file access and management. Systems will allow for access to scanning, visualisation, and classification for Word, Excel, JPEG, PDF, and other formats so that these file formats may be included in patient records.

Management

All of these functions will meet the requirements of relevant legislation regarding the confidentiality and security of data. Systems will be equipped with security fail-safes that allow for the management of access rights based on use profiles, access profiles, and work stations. The access log will also be available and will indicate the user name and information accessed.

The encoding of diagnoses will be conducted according to the standards established by the RAMQ, and will include CIM-9, CIM-9 CM, CIM-10, CIM-10 CA, and DSM 4.

The HL7 standard will be applied in communications with other programs in order to minimise adaptations to various interfaces, such as those in the laboratories, medical imaging facilities, pharmacies, and admissions services used by other systems or by other suppliers.

11. Organisation and budgeting guidelines

Clinics that apply for status as integrated GMFs and CRs must meet the accreditation criteria pertaining to GMF, CR, and integrated GMF and CR models.

DRMG guidelines regarding special medical activities (AMP) and the role of a head physician in a GMF and in a CR will apply, with any necessary modifications.

The funding granted to the medical clinics applying for status as integrated GMFs and CRs will be managed according to the rules and conditions outlined below.

Baseline conditions

Integrated GMFs and CRs must meet the following baseline conditions:

- 10 FTE physicians
- 1,500 weighted patient registrations per FTE physician
- Physicians' activities must meet the following conditions:
  - 70% of physicians practised mainly in their integrated GMFs and CRs.
  - 70% of each physician's[23] activities were dedicated to registered clientele.
  - 70% of the activities[24] of all physicians were dedicated to registered clientele within a six-month period.
  - 70% of patients saw, during this six-month period, a physician by appointment.

Targeted conditions

Once established, integrated GMFs and CRs must meet the following targeted conditions:

- 10 to 15 FTE physicians
- 2,000 weighted patient registrations per FTE physician
- Physicians' activities will have met the following conditions:
  - 70% of physicians practised mainly in their integrated GMF and CR entities.
  - 70% of each physician's activities were dedicated to registered clientele.
  - 70% of the activities of all physicians were dedicated to registered clientele within a six-month period.
  - 70% of patients, during this six-month period, saw a physician by appointment.

From the time a clinic receives its initial accreditation, it has 3 years to meet 80% of the targeted conditions (1,600 registrations per FTE physician, and 56% of medical activities), and 5 years to meet 100% of the targeted conditions (2,000 registrations per FTE physician, and 70% of medical activities).

Progressive budget

To facilitate the development of a straight-forward funding method, two calculation strategies have been employed. First, based on a detailed estimate of the various budget items necessary to the operation of integrated GMFs and CRs, a percentage of all recurring costs has been determined. This percentage will apply to the salary budget for the professionals hired, including coordination bonuses. Second, a progressive funding model has been designed, based on the number of projected patient registrations, and on the scale of the GMFs within the MSSS.

For example, a clinic with 15,000 registrations will receive funding for 10 FTE professionals, including those already associated with GMF and CR agreements. In addition to the salaries of the

[23] By appointment (RV), and on a walk-in (SRV) basis.
[24] By appointment (RV), and on a walk-in (SRV) basis.

newly hired professionals, recurring funding (32.7% of the salary of new professionals, with bonuses) will cover rent and leasehold improvements, administrative and support staff, and various operating costs related to the activities of employees.

Funding scale for the recurring budget

Weighted registrations	**15,000**	**19,000**	**24,000**	**30,000**
FTE professionals	10	11.4	13	15
GMF funding	$237,691	$285,582	$348,740	$422,338
CR funding	$130,000	$130,000	$130,000	$130,000
CSSS–Agence funding	$529,541	$607,263	$687,662	$955,281
Total funding:	**$897,232**	**$1,022,845**	**$1,166,402**	**$1,507,619**

In addition to GMF and CR funding, projected sources of funding will include the CSSS and the Agence (accounting for 50% each). For a more detailed look at budgets to be granted, see Appendix 7.

Every year, budgets could be indexed according to MSSS rates.

Funding from the Agence also includes the computerisation of these clinics, which is not included in the table, above. The TCR assessment includes hardware with software, necessary interfaces (laboratory, medical imaging, and ADT), training, and other items. For more details on funding sources, see Appendix 8.

TCR estimate for integrated GMFs and CRs with 10 FTE physicians, 10 FTE professionals, and the required administrative and support staff

Project cost		**Source of funding**					
		GMF		CR		GMF	
Cost	Recurring	Cost	Recurring	Cost	Recurring	Cost	Recurring
$615,100	**$152,420**	**$615,100**	**$152,420**	**$615,100**	**$152,420**	**$615,100**	**$152,420**

Standard contract

A standard contract will provide the basis for negotiations between the Agence, the CSSS, and the clinic (see Appendix 9). It will set out the objectives of the agreement, the parties' respective responsibilities (e.g., services and statements of charge and discharge), and other provisions. Among these provisions, the CSSS will have to ensure

- structured access to all services in its service-programs, with the exception of Home Care services for patients not residing within the local territory
- that a full description of the priority access mechanisms (referral and patient management) associated with its services be provided, in particular to the integrated GMF and CR staffs
- access allowing integrated GMFs and CRs to enter data on professional activities into a I-CLSC registry
- support for the writing, implementation, and follow-up of clinical protocols and of collective prescriptions

- follow-up and evaluation of attained results, conducted jointly with the Agence
- co-operation in allocating or assigning some or all of the required professionals to integrated GMFs and CRs, if necessary
- recurring funding for part of the costs associated with the operation of integrated GMFs and CRs

12. Evaluation

The *Orientations for the Development of Integrated Family Medical Groups and Network Clinics* divides evaluation into three parts: evaluation of the implementation of these new organizations, evaluation of the follow-up of management and deployment, and evaluation of the Montréal model of patient management, based on the needs of the population.

12.1. Evaluation of implementation

Evaluating implementation will provide a follow-up of the evolution of integrated GMFs and CRs to ensure proper development operations and to proceed with adjustments during development. This evaluation thereby will foster the harmonious development of integrated GMFs and CRs while respecting the principles of effectiveness, efficiency, adaptation, and quality.

This evaluation may be realised in collaboration with various universities.

12.2. Follow-up of management and deployment

The analysis of the management and deployment of these new organizations requires a set of indicators to assess the attainment of the integrated GMF and CR model's targeted results.

Data for some of these indicators will be drawn from statements of charge and discharge, produced in accordance with contracts pertaining to both CR and GMF statuses.

We have added another set of indicators, specifically formulated to evaluate the status of integrated GMF and CR entities (see Appendix 5).

The integrated GMF and CR evaluation framework will bring together all of the indicators contained in GMF, CR, and integrated GMF and CR contracts, and will be organised according to the four-quadrant performance model (effectiveness, adaptation, efficiency, and quality) developed by the Agence (see Appendix 1).

Effectiveness:	**Efficiency:**
➢ Avoidable hospitalisations[25] (integrated GMFs and CRs) ➢ *Influenza* vaccination rate for persons over 60 (integrated GMFs and CRs) ➢ Number of vulnerable orphan patients registered (patient cases managed) in one month by attending physicians (CRs)	➢ Average number of FTE physicians in a clinic (CRs) ➢ Number of registrations per FTE physician (integrated GMFs and CRs) ➢ Number of FTEs per type of professional (integrated GMFs and CRs) ➢ Number of interventions per FTE professional (integrated GMFs and CRs) ➢ Number of FTE administrative and support staff (integrated GMFs and CRs) ➢ Number of referrals per online *IISR* (integrated GMFs and CRs)

[25] The 14 medical conditions for which hospitalisation is deemed avoidable are as follows (Tousignant et al. 2000): ruptured appendix, pneumonia (ages 5–49), cellulitis (age 18 and older), diabetes (age 18 and older), heart failure (age 18 and older), hypokalemia (age 18 and older), gangrene (age 18 and older), malignant hypertension (age 18 and older), diseases that are avoidable via immunisation (age 18 and older), ulcer—perforated or haemorrhaging (age 18 and older), pyelonephritis (age 18

Adaptation:	**Quality:**
➢ Operating hours: medical services by appointment (RV) and walk-in clinics (SRV), for basic radiology and liaison staff consults (CRs) ➢ Number (integrated GMFs and CRs) and percentage of vulnerable clients registered (GMFs) ➢ Specific clientele follow-up (GMFs): o Number of patients followed at home o Number of deliveries (births) ➢ Evaluation of user satisfaction	➢ Number of patients aided by liaison staff in one month (CRs) ➢ Emergency access to service corridor with hospital centre (CRs): o Emergency laboratory o Emergency radiology o Emergency and semi-emergency specialty consultation ➢ Number of different multidisciplinary protocols (integrated GMFs and CRs): o Internal only o Inter-institutional ➢ Use of two specific protocols (integrated GMFs and CRs): o Diabetes o High blood pressure ➢ Number of patient case discussions held[26] per FTE physician (integrated GMFs and CRs)

As the clinical protocols are progressively implemented (including those for chronic diseases, like diabetes), quality indicators will be developed to measure observable results among the patients managed by integrated GMFs and CRs. Indicators could include: the percentage of diabetic patients whose Hb A1c levels are lower than 7%, the percentage of hypertensive patients with an ABP reading lower than 140/90.

Computer systems installed in integrated GMFs and CRs will have the capacity to supply the necessary data to monitor these kinds of indicators.

Moreover, registration and medical activity targets must be reached to maintain integrated GMF and CR accreditation.

12.3. Evaluation of the Montréal patient management model — Needs of the population

The results evaluation for integrated GMFs and CRs will focus on the longer-term impacts of this medical clinical model with regard to patient management for the population. In co-operation with the DSP, this more strategically oriented part of the evaluation will ultimately include data on improving the health and well-being of clientele.

Currently, the Agence and the 12 CSSSs are jointly developing a major health care and social service network performance evaluation project. This project takes the form of a strategic dashboard to help monitor a variety of indicators, in order to

- support the initiation of priority changes
- describe and follow the network's desired changes
- evaluate results

Evaluating the management of Montréaler's needs in primary medical and multidisciplinary services will be one of the cornerstones of this project.

To build its strategic indicators, the Agence has a matched data base that cross-references data on medical procedures, hospital activities, CLSC interventions, CHSLD intake, and mortality files.

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and older), phlebitis without pulmonary embolism (age 18 and older), occluded abdominal hernia (age 18 and older), and asthma (ages 5–49).

[26] This is a new professional activity that became billable for general practitioners in January 2007.

Within the framework of a project accepted by the Commission d'accès à l'information, these data were stripped of their identifying information and encrypted, maintaining only one client identifier. Therefore, using this tool, it will be possible to follow trajectories of care within the network in various points of service over several years. These trajectories could be analysed to follow the developments and outcomes of various forms of patient management (e.g., for GMFs, vulnerable registered clienteles, solo practices, and the absence of patient management).

With regard to evaluating specific results on integrated GMFs and CRs, applicable agreements must specify that physicians will authorise access to RAMQ information that identifies location of practice. Data will be analysed as it pertains to a specific integrated GMF and CR, rather than focussing on a specific physician. Agreements should also make provision for clientele information relating to non-medical, multidisciplinary integrated GMF and CR interventions, granting authorisation for access to non-identifying, encrypted data to allow for their integration into the matched data bank.

To evaluate the management of registered patients at integrated GMFs and CRs, a differentiated analysis will be conducted using selected PALV indicators (see Appendix 6).

During 2007, other indicators were proposed to evaluate the Montréal Action Plan for Hospital Discharge Patients and the Mental Health Action Plan.

CONCLUSION

The orientations in this document for the development of integrated GMFs and CRs provide a preliminary blueprint for an innovative organisation of primary medical and social services in Montréal. This document has drawn upon current international literature about various team and service models in primary care. [27]

Adapted to practice approaches and parameters that are specific to Québec (e.g., integrated health and social services), this document will facilitate the progression of co-operative work between general practitioners in private clinics and other regional health and social service resources, especially with professionals who will be called upon to work in tandem with them.

While the accessibility of medical services constitutes the foundation of our initiative, we are going further in our objectives, preparing primary medical and general services to accommodate an aging population with specific needs (e.g., chronic diseases) and handicaps requiring expertise from a variety of health care professionals. In a context of staffing and other shortages, the integrated GMF and CR approach focuses on professional integration and the efficiency of the network's human resources.

In addition to an approach that resolutely targets prevention and altering risk factors, the integrated GMF and CR model also promotes patient empowerment and the continuity of services.

By focussing on the clinical integration of resources for specific clientele through multidisciplinary clinical protocols, this model establishes the basis for improved patient management for those who need it most.

These partnerships between physicians and the network will usher in a new era in Québec, with the introduction of evaluation frameworks that include quality indicators. Indeed, the integrated GMF and

[27] Regarding family medicine the Collège des médecins du Québec states that primary care offered that is offered must meet WHO primary care standards. These include preventive care, curative care, rehabilitation, and palliative care. These services are available 24 hours a day, 7 days a week. They are universal and continuous, and include long-term patient management. *(Collège des médecins du Québec, 2000)*.

CR evaluation framework is based on selected high-performance health care models, established through best clinical practice data and will be increasingly based on observable health care outcomes.

Based on the advantages this partnership affords (e.g., access to a multidisciplinary team and centralised computer technology), we predict that a convergence of objectives and practices will lead CRs to apply for CR-GMF status, and that GMFs will apply for GMF-CR status. Indeed, even before work on this project was completed, several GMFs and CRs were approached and said they would take advantage of this opportunity to apply for integrated GMF and CR status.

The Agence is now concentrating its efforts on developing adaptive deployment strategies for integrated GMFs and CRs. These strategies will allow for possible variations on the model (e.g., private, UMF, and university centre models) and will respect local specificities.

Over the long term, a new network of approximately 60 CRs could be on the leading edge of patient management for the population of Montréal.

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- Chicoine, Guy. *La prestation des soins de santé chez Kaiser Permanente***,** Care Management Institut.
- Trudell, Beth. *Les patients comme partenaires : aide à l'autogestion des soins à Kaiser Permanente,* Kaiser Permanente International.
- Wallace, Paul. *Gestion des soins : Faciliter les bonnes actions : Un modèle de prise en charge de la population.* Care Management Institut, Kaiser Permanente.
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- Casasa Plana, Dr. Albert. *L'exemple du service de première ligne Sardenya*.
- Davins, Dr. Josep. EAP La Mina. *Population, professionnels, organisation, résultats*.
- Plaza, Aina. *Évaluation—instrument d'amélioration des services de santé publique*.
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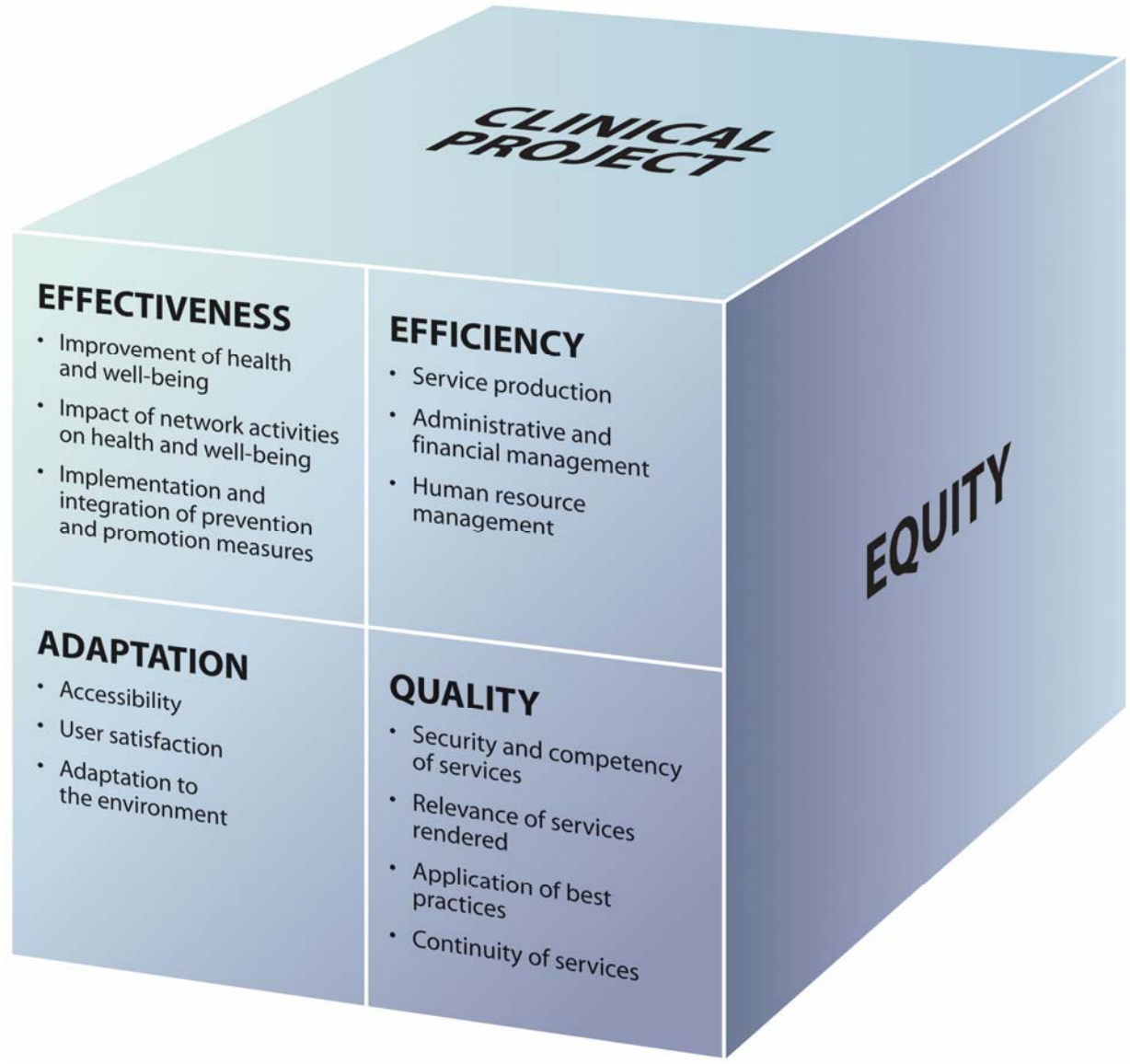
APPENDIX 1: THE AGENCE'S FOUR-QUADRANT PERFORMANCE MODEL



APPENDIX 2: A YEAR IN THE LIFE OF AN INTEGRATED GMF AND CR ENTITY

Parameters	Integrated GMFs and CRs	All of MTL
Ages 0–14[1]	5,690	355,235
Ages 15–64[1]	19,783	1,235,120
Age 65 and older[1]	4,527	282,660
Persons living with diabetes[2]	1,920	119,873
Persons living with heart failure[3]	300	18,730
Persons living with COPD[4]	1,410	88,032
Persons living with a long-term activity limitation	2,670	166,698
Pregnancies/year[6]	552	34,463
Mortality[7]	246	15,359
Depression[8]	1,470	91,778
Interventions in routine health care services[9]	7,177	448,080
Interventions in psychosocial services and others, excluding SAD[9]	856	53,445
Total hospitalisations (04–05)[10]	**2,678**	**167,202**
Surgery	606	37,841
Medicine	1,239	77,353
Newborns	333	20,795
Obstetrics	369	23,007
Psychiatry	131	8,206
Specific surgery (04–05)[11]		
Cataracts	414	25,843
THR–TKR	57	3,546
Bypass/Valve	81	5,054
Population:[12]	**30,000**	**1,873,015**

1 Data on the CMIS site, Agence of Montréal, Statistiques interactives, Projections 2004.

2 Prevalence of diabetes in Montréal: 6.4%, data from the Montréal DSP, 2006.

3 Prevalence of heart failure: Literature from Europe and the United States indicate a prevalence of between 0.5% and 2%. Our approximation is 1%.

4 Prevalence of COPD in Montréal: 4.7% among persons age 12 and older, according to the Montréal DSP.

5 Prevalence of people living with a long-term activity limitation: 8.9 % according to the INSPQ, 1998.

6 Pregnancies per year in Montréal: 34,352 pregnancies in 2002 for a population of 1,860,748 or 1.84%, according to the Montréal DSP.

7 Annual mortality rate in Montréal: 15,265 deaths in 2003 for a population of 1,866,017, or 0.82%, according to the Montréal DSP.

8 Prevalence of depression: Statistics Canada's *Canadian Community Health Survey* reports a prevalence of 4.9% in Québec, 2002.

9 Data on the CMIS site, Agence of Montréal, Statistiques interactives, I-CLSC, Projections 2004.

10 CMIS, the Agence of Montréal, Med-Écho data, 2004–2005.

11 Data on surgery waiting lists, Direction générale associée, the Agence of Montréal, 2004–2005.

12 Data on the CMIS site, Agence of Montréal, Statistiques interactives, Projections 2004.

APPENDIX 3: TECHNICAL PLATFORMS AND DIAGNOSTIC SERVICES

Basic radiology examinations

- Radiograph (e.g., lungs, sinuses, skull, abdomen, extremities)

Emergency samples collected for laboratory tests

- CSF, glycaemia, electrolytes, creatinine, monotest, hepatic check-up, TSH, uric acid, INR, Beta subunit of HCG, troponin
- Strep-test
- Urinanalysis
- Specimen for culture

APPENDIX 4: COLLECTIVE PRESCRIPTIONS

What information should a collective prescription include?

When writing collective prescriptions for a GMF, physicians should ensure that they include the following information in order to comply with the *Regulation respecting the standards relating to prescriptions made by a physician* set forth by the Collège des médecins du Québec:

1. **Name of the person or persons entitled to carry out the prescription**

2. **Circumstances such as**
   a. Clinical situation
   b. Category of clientele or clienteles

3. **Names of all prescribing physicians**
   a. Name written in block letters or printed
   b. Telephone number
   c. Number of permit to practise
   d. Signatures of the prescription by all physicians

4. **In the case of medication**
   a. Directions for use, including the pharmaceutical form
   b. Concentration, if applicable, and dosage
   c. Method of administration
   d. Duration of treatment or the amount prescribed
   e. Number of renewals authorised, or indication that no renewal is authorised
   f. Patient's weight, if applicable
   g. Therapeutic intention, if deemed useful
   h. Name of any medication the patient must cease taking
   i. Prohibition against substituting medications, if applicable

5. **In the case of an examination**
   a. Nature of the examination
   b. Clinical information required to conduct the examination

6. **In the case of a treatment**
   a. Nature of the treatment
   b. Description of the treatment, if applicable
   c. Duration of the treatment, if applicable
   d. Any contraindications
   e. Any other information required by the patient's condition

7. **Validity period of the prescription, when warranted by a patient's condition**

8. **Reference to a protocol, if applicable**
   It should be noted that when such a reference is included, a prescription written outside of an institution may only refer to a protocol applicable in an institution within the territory where the physician carries out his or her professional duties.

APPENDIX 5: INDICATORS FOR CRS, GMFS, AND INTEGRATED GMFS AND CRS

A. Specific follow-up for integrated GMFs and CRs

Since the Agence and the local CSSS will be supplying resources to integrated GMFs and CRs, integrated GMFs and CRs will issue statements of charge and discharge on the use of funding, in accordance with the *Orientations for the Development of Integrated Family Medical Groups and Network Clinics* and the contract signed by the parties. This information may be provided along with CR status data and will be sent on a biannual basis (every six months) to the CSSS and the Agence (DRMG).

Integrated GMF and CR follow-up indicators

- Number of FTEs per type of professional
- Number of interventions per FTE professional

  Interventions will be broken down as follows:
  1. *Main activity (e.g., educational and preventive education in physical health care)*
  2. *Intervention profile (e.g., post-operatory physical health)*
  3. *Type of professional (e.g., social worker)*
  4. *Centre of activity (e.g., psychosocial services other than SAD)*
- Number of FTE administrative and support staff
- Number of *patient case discussions*[28] by clinic physicians
- Number of referrals via online Inter-Institution Service Request (IISR)
- Rate of avoidable hospitalisations[29]
- Rate of *influenza* vaccination for the population age 60 and older
- Number of different multidisciplinary protocols:
  i. Internal only
  ii. Inter-institution
- Use of two specific protocols:
  1. *Diabetes*
  2. *HTA*
- % of targets reached (number of registrations and medical activities)

B. GMF follow-up currently applied (biannual)

GMF follow-up indicators

- FTE physicians
- Registration target (1,500/FTE physician)
- Medical follow-up of specific clienteles
  - Number of persons followed-up at home
  - Number of deliveries
- Registration target after weighting (SAD and obstetrics)
- Number of registrations
- % of target reached
- % of vulnerable clientele

[28] This is a new professional activity that became billable for general practitioners in January 2007.
[29] This indicator will be provided on a post-event, annual basis.

GMF: Other information

- Current GMF schedule: Day? Night? Walk-in?
- Weekend and statutory holidays: Coverage by physicians from the GMF? Or shared? With whom? Effective on what date?
- 24/7 on-call services (for vulnerable clientele registered with the GMF): Coverage by physicians from the GMF? Or shared? With whom? Effective on what date? Participation in regional on-call services?
- Connections with Info-Santé for 24/7 on-call services: clientele registered with Info-Santé? Number of persons registered at Info-Santé? Clientele registered? From the SAD program of the CLSC? Or GMF patients at risk for decompensation.
- Team work: Are there team meetings? How frequent are they? Do nurses participate?
- Functional access to services established with the CSSS or with other entities: To general services? To investigation services? To other specialties?

C. CR follow-up currently applied (each fiscal period)

CR follow-up indicators

- CR hours of operation[30]
  - Medical services by appointment (RV)
  - Walk-in medical services (SRV)[31]
  - Basic radiology[32]
  - Liaison agent[33]

- CR clientele services
  - Medical services by appointment
    - Average number of hours of clinical activities/week[34]
    - Average number of consults/week[35]
    - Number of consults/hour
  - Walk-in medical services
    - Average number of hours of clinical activity/week
    - Average number of consults/week
    - Number of consults/hour
  - Average total hours of clinical activities/week
  - Percentage of consults by appointment
  - Vulnerable orphan patients:[36] Number of vulnerable orphan patients registered during the month by attending physicians

[30] In this section, write the regular hours of operation during the month. If real hours worked differ from regular hours of operation, provide details in the "Comments" section. If there is no statutory holiday during a particular month, do not write anything in the "Statutory Holiday" section.
[31] In this section, write the normal walk-in (SRV) hours of operation. During this schedule period, the closing time specified should indicate the time at which the last patient can enter the clinic.
[32] A network clinic must provide at least 6 days of radiology service per week, or 6 hours per day during the week, and 4 hours per day on weekends and statutory holidays.
[33] A network clinic must provide a liaison service throughout its hours of operation. In this section, provide the work schedule of CR liaison agents, rather than the hours of all of the liaison activities worked by network clinic staff.
[34] In this section, write the average of all network clinic physicians' hours of activities per week, including hours of clinical-administrative work (signature of results, calls to patients).
[35] In this section, write the number of consults per week. This number must be an average and not a precise, week-by-week breakdown.
[36] In this section, write the number of vulnerable patients (as defined in the agreement between the MSSS and the FGPQ) and orphan patients (i.e., any patient who does not have or no longer has a family physician) whose care is now managed by a CR physician, regardless of whether they have actually met with this attending physician. All patients referred by hospital emergency services are given priority, although not to the exclusion of other patients.

- Liaison service:[37] Number of patients to receive orientation services from liaison staff during the month
- Basic radiology examinations: Number of patients seen[38] during the month

- Medical resources:
  - Network clinic physicians
    - Number of general practitioners
    - Average number of FTE[39] general practitioners

- Emergency access to service corridor with hospital centre
  - Laboratories[40] (emergency): Number of patients for whom an emergency sample has been carried out at the network clinic and sent to the hospital during the month
  - Radiology: Number of patients referred to hospital Radiology as emergency cases during the month
  - Specialty consultation[41] (emergency and semi-emergency)

[37] In this section, write the number of patients who receive guidance from the network's liaison staff, either for an emergency situation (e.g., service corridors) or a non-emergency situation.
[38] In this section, write the number of patients who received prescriptions for radiography from a CR physician. One person who is seen twice in the same month must be counted as 2 patients. The CR must ensure that data from all clinical activities in radiology are differentiated from overall clinical radiology activities when radiology services are integrated into the CR; and when patients are referred to an associated radiology clinic, must take that data into account.
[39] One FTE "Full-time equivalent" = 35 hours per week. Calculations here must pertain to generally reliable core staff, independent of the real number of hours worked.
[40] In this section, write the number of patients who have received on-site emergency sample collection services.
[41] This section is reserved for the corridor associated with the hospital. Other speciality referrals should be entered in the "Liaison Service" section.

APPENDIX 6: PERSONS EXPERIENCING A LOSS OF AUTONOMY ASSOCIATED WITH AGEING — PALV INDICATORS

Effectiveness: ➢ Proportion of elderly persons, age 75 and older, who have been to an emergency ward ➢ Proportion of elderly persons, age 75 and older, for whom a residency application has been filed with the regional admissions system (SRA)	**Efficiency:** ➢ Rate of institutionalisation of persons age 75 and older per local health network territory (not applicable to patient management analysis in integrated GMFs and CRs) ➢ Expenditures in the community (not applicable to patient management analysis in integrated GMFs and CRs)
Adaptation: ➢ Average number of days for persons age 75 and older between discharge from an emergency ward and the first CLSC PALV intervention (710 profile) ➢ Number of days waited to obtain an permanent place of residence in a CHSLD, from the time the application for residency was filed with the (SRA) until the initial date of admission to the CHSLD	**Quality:** ➢ Proportion of users who have returned to an emergency ward within 10 days of their first discharge from a hospital centre ➢ Proportion of users age 75 and older who have received at least one intervention from a CLSC within 28 days of their admission to an emergency ward ➢ Proportion of persons age 75 and older who have received at least one CLSC PALV intervention (profile 710) per budgetary period during at least three consecutive periods in one year (continuous care) ➢ Average number of interventions received by elderly persons, age 75 and older, who have received continuous PALV services (profile 710) (one intervention per month for at least three consecutive months) ➢ Proportion of users age 75 and older who, three months before their visit to an emergency ward, had not met with at least one general practitioner in a medical clinic

APPENDIX 7: BUDGET DETAILS

Integrated GMF and CR team of professionals

- The projected team ratio: one FTE professional to one FTE physician.
- The composition of the team will be based on the example provided in this document, but will be adjusted to the needs of integrated GMF and CR clientele.
- Salary levels will start at 3/4 of their applicable salary scale. For example: nurse clinicians 14/18; nursing assistants 8/10; physiotherapists 14/18; and so on.
- These hourly salaries will be multiplied by 35 hours, and then by 52.18 weeks. Next, 30% for the employer's share and social benefits will be added.
- A coordinating bonus will be allotted by five FTE professionals. It will be a 10% bonus,[42] adjusted according to professional category.

Integrated GMF and CR office equipment

- Non-recurring funding is $2,000 per additional work station.
- This funding covers moveable property for non-medical staff. It will not be used for medical supplies, photocopies, medical equipment, or computer equipment.

Costs related to training replacement staff

- Funding for costs related to training replacement staff is based on GMF funding: 17 hours of training per employee, multiplied by $35, plus 7 hours of training per employee, multiplied by $35.
- This funding is earmarked for training new employees (professional and administrative) in their duties at integrated GMFs and CRs, and includes computer training (Lotus Notes) and patient registration.

[42] The bonus is calculated based on gross wages, before benefits and the employer's share are added.

APPENDIX 8: COMPUTER PLATFORM COSTS AND FUNDING SOURCES

CRI - 15 FTEs	Project cost		Funding source					
			GMF		CR		CRI	
	Cost/Total	Recurrence	Cost/Total	Recurrence	Cost/Total	Recurrence	Cost/Total	Recurrence
Hardware	$140,500.00	$28,100.00	$56,000.00	$11,200.00	-	-	$84,430.00	$16,886.00
Software	$208,600.00	$41,720.00	$36,900.00	$7,380.00	$23,850.00	$4,770.00	$147,746.00	$29,549.20
Training	$25,000.00	$5,000.00	$6,500.00	$1,300.00	$2,500.00	$500.00	$17,000.00	$3,400.00
Lab, Rad., ADT interfaces (CSSS)	$105,000.00	$21,000.00	-	-	$17,500.00	$3,500.00	$17,500.00	$3,500.00
Professional services	$20,000.00	$4,000.00	-	-	$10,000.00	$2,000.00	$10,000.00	$2,000.00
Telecommunications	$500.00	$2,500.00	-	-	$250.00	$1,250.00	$250.00	$1,250.00
Support	$20,000.00	$20,000.00	$700.00	$700.00	-	-	$19,300.00	$19,300.00
Local project management	$25,000.00	$5,000.00	-	-	$12,500.00	$2,500.00	$12,500.00	$2,500.00
Change management	$50,000.00	$10,000.00	-	-	-	-	$50,000.00	$10,000.00
Technocentre (TCR) support	$13,750.00	$13,750.00	$5,000.00	$5,000.00	-	-	$50,000.00	$8,750.00
TCR project management	$50,000.00	$10,000.00	-	-	$25,000.00	$5,000.00	$25,000.00	$5,000.00
	$658,350.00	**$161,070.00**	**$105,100.00**	**$25,580.00**	**$91,600.00**	**$19,520.00**	**$433,726.00**	**$102,135.20**

CRI - 10 FTEs	Project cost		Funding source					
			GMF		CR		CRI	
	Cost/Total	Recurrence	Cost/Total	Recurrence	Cost/Total	Recurrence	Cost/Total	Recurrence
Hardware	$128,000.00	$25,600.00	$43,500.00	$8,700.00	-	-	$84,430.00	$16,886.00
Software	$180,350.00	$36,070.00	$27,400.00	$5,480.00	$4,020.00	$4,020.00	$147,746.00	$29,549.20
Training	$22,500.00	$4,500.00	$5,666.67	$1,133.33	$333.33	$333.33	$16,166.67	$3,233.33
Lab, Rad., ADT interfaces (CSSS)	$105,000.00	$21,000.00	-	-	$3,500.00	$3,500.00	$17,500.00	$3,500.00
Professional services	$20,000.00	$4,000.00	-	-	$2,000.00	$2,000.00	$10,000.00	$2,000.00
Telecommunications	$500.00	$2,500.00	-	-	$1,250.00	$1,250.00	$250.00	$1,250.00
Support	$20,000.00	$20,000.00	$700.00	$700.00	-	-	$19,300.00	$19,300.00
Local project management	$25,000.00	$5,000.00	-	-	$2,500.00	$2,500.00	$12,500.00	$2,500.00
Change management	$50,000.00	$10,000.00	-	-	-	-	$50,000.00	$10,000.00
Technocentre (TCR) support	$13,750.00	$13,750.00	$5,000.00	$5,000.00	-	-	$50,000.00	$8,750.00
TCR project management	$50,000.00	$10,000.00	-	-	$5,000.00	$5,000.00	$25,000.00	$5,000.00
	$615,100.00	**$152,420.00**	**$82,266.67**	**$21,013.33**	**$18,603.33**	**$18,603.33**	**$432,892.67**	**$101,968.53**

APPENDIX 9: STANDARD CONTRACT BETWEEN THE CLINIC, THE CSSS, AND THE AGENCE

N.B. This document is provided for information purposes only and does not carry force of law. The French version of this contract is the only legally binding version.

CONTRACT BETWEEN

The *MEDICAL CLINIC*
REPRESENTED BY:

The *HEALTH AND SOCIAL SERVICE CENTRE (CSSS)*
REPRESENTED BY:

AND

The *AGENCE DE SANTÉ ET DE SERVICES SOCIAUX DE MONTRÉAL (Agence)*
REPRESENTED BY:

1. DESCRIPTION OF THE PARTIES TO THE CONTRACT

The …….. **medical clinic** or **centre**, hereinafter referred to as "the INTEGRATED GMF and CR"

situated at: .....

situated at: _____

The **Health and Social Service Centre,** hereinafter referred to as the "CSSS," its head offices situated at:

_____

The **Agence de santé et de services sociaux,** hereinafter referred to as the "Agence,"

situated at: .....

2. PURPOSE OF THE CONTRACT

The purpose of this contract is to establish an integrated family medical group and network clinic that brings general practitioners together with other health care professionals (nurse clinicians, nurses, psychologists, social workers, physiotherapists, nutritionists, respiratory therapists, and others), an administrative and support team, and possibly some medical specialists.

The medical clinic applicant for integrated GMF and CR status has fulfilled the dual status requirements as a network clinic (CR) and a family medical group (GMF). This contract establishes a partnership between a group of general practitioners, a CSSS, and the Agence.

The specific objectives of this contract, in addition to the objectives previously set out in the CR and GMF contracts, are as follows:

- to increase accessibility to primary care medical patient management;
- to provide general holistic, multidisciplinary, continuous, quality medical services;

- to provide follow-up with nursing care and consultations, and short-term follow-up with psychology, social services, nutrition, physiotherapy, and other professional services;
- to maximise the use of professional expertise and to increase work organisation efficiency in medical and general primary care medical services;
- to foster improvement in the health of clientele and in the reduction of possible risk factors through an integrated preventive approach;
- to develop, through with education and support, patients' empowerment and self-management regarding factors influencing their health;
- to facilitate operations as an integrated network by using multidisciplinary and possibly inter-institution clinical protocols;
- to enhance the accessibility of medical specialists on site or via service corridors for clientele, by working with the CSSS or with the primary partner hospital.

3. OBLIGATIONS OF THE PARTIES

The CSSS undertakes to ensure:

- structured access to all of the services in its service-programs, with the exception of Home Care services (SAD) for patients not residing within the local territory;
- that a full description of the priority access mechanisms (referral and patient management) associated with its services be provided, in particular to integrated GMF and CR staff;
- access for the integrated GMF and CR to an I-CLSC registry so that it can input data associated with the activities of its professionals and thereby provide a statement of charge and discharge, as outlined in Schedule C;
- support for the writing, implementation, and follow-up of clinical protocols, and of multidisciplinary and possibly inter-institution collective prescriptions;
- co-operation in allocating or assigning to the integrated GMF and CR, if necessary, some or all of the required professionals, including replacements. The selection of such professionals shall be carried out by a joint committee comprised of CSSS and integrated GMF and CR representatives, which committee shall establish a selection procedure;
- a follow-up and evaluation of attained results, conducted jointly with the Agence;
- recurring funding of a portion of the costs associated with the application of this contract, as stated in Schedule A, attached.

The last obligation mentioned above may also take the form of a staff allocation or assignment, pursuant to the funding sum(s) specified in Schedule A, and subsequent to the conclusion of a contract to this effect with the integrated GMF and CR. At such time, the CSSS may remain the employer or the paymaster of the professionals, who shall continue to be regulated under the provisions of their collective agreement. Conversely, the professionals hired at the integrated GMF and CR shall work under the authority and the functional responsibility of the integrated GMF and CR and its head physician.

The integrated GMF and CR undertakes to ensure:

- the services set forth in its agreements in regard of its dual status as a CR and as a GMF;
- a registration process that prioritises vulnerable clientele, and particularly vulnerable clientele from the local integrated GMF and CR network;
- follow-up with nursing care and consultations in psychology, social services, nutrition, physiotherapy, and other fields of practice, in accordance with the expertise of the professionals hired;

- health promotion, information, and education services, in co-operation with the local territory CSSS Health Education Centre (CES);
- participation from the integrated GMF and CR medical team in providing in-home maintenance, including medical house calls, for patients that it has registered for Home Care services (SAD), in co-operation with the CSSS;
- compliance with the access priority mechanisms (referral and patient management) as described by the CSSS;
- communication of relevant information to the CSSS, at the time of their registration, in regard of patients residing in the local territory;
- compliance with work conditions on the part of the employees (professionals and others) allocated or assigned to the integrated GMF and CR;
- civil and professional liability insurance coverage for the clinic and its staff;
- that the human and financial resources described in Schedule A, be used solely for the stated purposes, and in compliance with the terms and conditions stipulated in Schedule B, attached;
- that the CSSS and the Agence be provided with a professional service provider activity log, as per the description of the statement of charge and discharge in Schedule C;
- that written notification be provided to the CSSS and the Agence regarding the arrival or departure of any team member working for the integrated GMF and CR (physicians or other professionals), no later than thirty (30) days after said member's date of arrival or departure;
- that it submit reports every six (6) months in regard of the administration and management of the human and financial resources granted for the purposes stated herein. To this end, upon demand, the integrated GMF and CR undertake to provide the CSSS and the Agence with any document or information regarding the administration of human and financial resources described in Schedule A and B of this contract;
- that the CSSS and the Agence or one of their authorised representatives, upon the expiry of a one-week notice issued by the CSSS or by the Agence during regular hours of operation: be granted access to the integrated GMF and CR's accounting records and ledgers pertaining to the administration of granted human and financial resources; and, subject to the provisions of the *Code of Ethics* laid down by the Collège des médecins du Québec, be granted access to information in regard of the subject matter set out in Schedules A and B, attached; and, subject to the same provisions, be allowed to make copies of the aforementioned documents.
- that all of the documents and attachments related to the administration of the human and financial resources granted by the CSSS and the Agence be kept for a period of at least five (5) years following the expiry date of this contract. The integrated GMF and CR also undertakes to allow access to a representative authorised by the CSSS or by the Agence;
- that any service agreement required for the purpose of this contract be concluded in order to assume its obligations hereunder.

The Agence, its Regional Department of General Medicine (DRMG) and its Regional Technocentre undertake to ensure:

- that they shall support and facilitate the integrated GMF and CR in concluding service agreements entered into in compliance with section 108 of the *Act respecting health services and social services*;
- that they shall supply the integrated GMF and CR, as stipulated under the terms of Schedule B of this contract, with the financial resources described in Schedule A of same;
- that a follow-up and evaluation of target result attainment be jointly carried out with the CSSS;

- that they recognise that the professionals, administrative staff, and support staff that they partially fund, engage in their activities under the hierarchal authority of the integrated GMF and CR;
- that they supply the integrated GMF and CR with computer systems, including the installation and connections of same, as specified in Schedule A.

As of the signatory date of this contract, the medical team comprises …. physicians, representing .... FTEs. These physicians (or some of them) representing …. FTEs, have signed a mandate authorising the head physician to sign this contract. *[In the event that a person other than the head physician signs on behalf of the* integrated *GMF and CR, add the following paragraph.]*

The head physician is responsible for the allotment of the sums granted to the integrated GMF and CR as stipulated in Schedule A of this contract, and for the follow-up thereof. Allotting these sums aids in establishing conditions of practice and professional workplaces conducive to attaining targeted service offering objectives.

4. JOINT COMMITTEE

The signatories undertake to strike a joint committee to monitor compliance with the terms of this contract. The committee shall undertake to ensure:

- that the means of implementation and provision timetables for establishing the service offering are described;
- that target results be determined in regard of service delivery;
- that attained results be periodically evaluated in order to take any necessary corrective action and, at least once a year or upon request, submit a report to the partners and to the Agence;
- that any dispute or disagreements between the signatories be examined so as to implement appropriate solutions;
- that the detailed statements of charge and discharge produced by the integrated GMF and CR for the CSSS, or by the CSSS for the Agence be examined.

At their discretion, the parties may invite a representative from the Agence and/or the Board of Directors of the Regional Department of general medicine (DRMG) to participate in the Joint Committee's meetings.

5. ORIENTATIONS FOR THE DEVELOPMENT OF INTEGRATED GMFs AND CRs

The signatories undertake to comply with the *Orientations for the Development of Integrated Family Medical Groups and Network Clinics* produced and updated by the Agence in Schedule D of this contract.

6. OTHER PROVISIONS

6.1. ARBITRATION

The CSSS and the integrated GMF and CR agree to submit any dispute concerning the interpretation, the application, or the management of this contract to an arbitrator, saving and accepting any civil or administrative tribunal. The arbitrator shall be chosen jointly by the CSSS and the integrated GMF and CR from a list of arbitrators compiled by the MSSS and the Federation of General Practitioners of Quebec, as specified in an agreement duly negotiated between them under section 19 of the *Health Insurance Act.*

Failing an agreement, either of the parties may ask the head arbitrator to assign an arbitrator from the aforementioned list. The arbitrator's expertise, the arbitration procedure, and the binding nature of the decision are the same as those set out in the *Code of Civil Procedure,* as amended from time to time.

6.2. CONFIDENTIALITY OF IDENTIFYING INFORMATION

The integrated GMF and CR recognises that confidential information concerning any natural person that allows same to be identified are governed by provisions of the *Act respecting access to documents held by public bodies and the protection of personal information* (R.S.Q., c.A-2.1) and the *Act respecting the protection of personal information in the private sector* (R.S.Q., c.P-39.1).

6.3. RESCISSION

In the event that one of the parties is in breach of this contract, either party may rescind same by providing ninety (90) days notice or by paying an indemnity in lieu thereof. If an agreement is not reached in regard of the amount of the indemnity to be paid, the dispute shall be subject to arbitration, as set out in 6.1.

6.4. RENEWAL

To renew this contract, the integrated GMF and CR must submit a written application to the CSSS six (6) months, at the latest, before the contract expiry date. During this period, the CSSS, in co-operation with the Agence and its DRMG, must complete an evaluation in regard of the attainment of targeted results and the use of the human resources granted during the period covered by the expiring contract.

6.5. DURATION OF THE CONTRACT

This contract enters into force on the day of its signature and shall be valid for five (5) years.

7. SIGNATURES

Name of signatory, Title **Name of clinic — for the integrated GMF and CR**	**Name of signatory, Title** **Name of CSSS — for the CSSS**

And

The intervenor signifying his agreement with this contract,

David Levine, President and Executive Director of the Agence of Montréal (DATE)
(FOR AGENCE DE LA SANTÉ ET DES SERVICES SOCIAUX DE MONTRÉAL)

Documents to attach to this contract:

A: Financial Summary
B: Means of Funding
C: Statement of Charge and Discharge
D: *Orientations for the Development of Integrated Family Medical Groups and Network Clinics*

Agence de la santé
et des services sociaux
de Montréal
Québec