Action for Health

Montreal Improvement Plan for Health and Well-Being

2003–2006

Consultation paper

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de Montréal-Centre

Note: In the text, the masculine pronoun is generic and refers to both women and men.

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2003–2006

Table of content

1.
Message from the President and Executive Director

HEALTH AND WELL-BEING FOR THE POPULATION OF MONTREAL

A Collective Challenge

The Regional Board is undertaking a process aimed at providing Montreal with a new strategic plan that will extend from the spring of 2003 to that of 2006. We therefore need to work together to identify our priorities for improving the health and well-being of Montreal's population.

On the basis of the results observed at the end of the 1998-2002 plan for health and access to services, we will have to make choices and implement the most appropriate solutions for efficiently providing prevention, cure, and treatment. This is a major challenge, one that compels us to make the right decisions, and I encourage Montrealers to respond to it.

The findings of this consultation process will enable me to submit a strategic three-year plan to the board of directors of the Regional Board in June of this year. This plan will be a response to the particularities of the Montreal metropolitan area as well as to the national priorities for the entire population of Quebec.

Hoping that the consultation will prove fruitful,

President and Executive Director
David Levine

2.
Welcome to participants

Concrete actions

This consultation paper presents the concrete actions outlined in the reference document for the Montreal-Centre Regional Board's 2003-2006 strategic plan, Action for Health, Montreal Improvement Plan for Health and Well-Being. It sets out, for easy reference, the proposed actions for each of the six priorities and four management challenges selected as the focus of the present consultation. We invite you to comment on these actions and improve them. However, participants are invited to read very carefully the information and context for each priority, found in the supporting document posted on the Regional Board's Website. This information is rich in new data, and will enable a more informed debate.

Information and consultation activities

There is a wide range of information and consultation activities planned. Different possibilities are open to you, depending on the presentation you would like to make, or the role you play within Montreal society. Consult the summary table at the end of this document. You will also find information on all scheduled activities, as well as the procedure for participating in those activities.

Questionnaire

In order to guide discussion and make it easier to combine your comments and suggestions, we suggest that you use the questionnaire at the end of this document. It will enable you to make your opinions on one or various priorities known, according to your interests and concerns.

To find out more

The draft 2003-2006 strategic plan incorporates all proposals linked to service organisation, the Public Health Action Plan, and the organisation of general and specialised medical services. If you wish to familiarise yourself with the content of these specific plans, visit the Regional Board's Web site. You will also find a wealth of complementary information. www.santemontreal.qc.ca

General information

Communications Department: 286-6500, extension 5612.

3.
An Integrated consultation approach

Decisionmakers who are there to listen

The consultation process will be conducted by the President and Executive Director of the Regional Board, David Levine, and the members of the Board of Directors on the Planning and Evaluation Committee. They will receive the submissions and comments of the various participants in the consultation. The President and Executive Director will request a submission from the Forum de la population (People's Forum), a new body set up as part of network management reform. This means that the comments made by users' committees and individual users will be analysed by the People's Forum, which will then incorporate them into its submissions on the regional plans.

Following the consultation process and once the results have been analysed, the Planning and Evaluation Committee will recommend, for adoption by the Board of Directors, the Strategic Plan for Service Organisation and the Montreal Public Health Action plan for 2003-2006.

Consultation activities that are tailored to the various audiences and regional plans

Consultation methods were chosen to encourage the greatest number of persons, groups and institutions to express their views.

Measures have been planned to bring together regional actors and partners who are directly involved in the proposed solutions, and whose contribution is essential to achieving the targeted objectives for improving the health and well-being of Montrealers.

In the case of the Organisation Plan for General Medical Services, and in order to reach as many of Montreal's 2 190 general practitioners as possible, the consultation foresees representative panels of physicians, exchanges with members during the General Annual Meeting, and collection of their submissions in written or electronic form.

With regard to the Montreal Organisation Plan for Specialised Medical Services, the following bodies will be consulted specifically for the Regional Medical Commission's submission: the Council of Physicians, Dentists and Pharmacists, professional service directors, the Order and professional associations, and the two faculties of medicine.

The regional commissions (medical, nursing, multidisciplinary) will be informed and consulted in the course of their regular meetings.

PARTICIPATION AND CONSULTATION: WHO, WHERE, WHEN AND HOW?

For individual Montrealers, institution groupings, community organisation groupings, regional medical associations, regional unions, groups representing the population, socioeconomic organisations or any other interested regional organisation.

Written submissions with or without public hearing

Interested regional groups, associations or organisations may make a written submission. They will then have the option of presenting it at a public hearing, or sending it for consideration without further presentation. The public hearing format is particularly relevant for community groups and organisations that cover the entire region. A consultation notice inviting groups to register in advance will be published in daily newspapers, one month prior to the consultations.

Procedure

Advance registration:
Participants in the public hearings must register before April 10th, 2003, at the Regional Board, by phoning: (514) 286-6500, extension 5612.

Written submissions

Organisations that wish to present their submission at the public hearings must send 15 copies of their document to the Regional Board before April 10th, 2003. Written submissions must be accompanied by a two-page summary. If the submission does not exceed 10 pages, the summary is optional.

All written submissions must be available in electronic format. They will be posted on the Regional Board's Website under the heading 2003-2006 Strategic Planning "*Action for Health*".

Consultation - Public hearings

Communications Department
Régie régionale de la santé et des services sociaux de Montréal
3725, rue St-Denis
Montreal (Quebec) H2X 3L9

Internet address for electronic transmission of written submissions

lise_latourelle@ssss.gouv.qc.ca

Dates and place

April 22, 23 and 24, 2003
Holiday Inn Midtown, Ambassador Room - 420 Sherbrooke Street West, Montreal (Quebec)

Length of presentations

Participants are granted 15 minutes each. They have 10 minutes to present their submission, and 5 minutes to answer the committee's questions.

All submissions from individual Montrealers will be forwarded to the People's Forum to be taken into account in the preparation of its submission. There will furthermore be a space reserved for Montrealers who wish to make themselves heard at the public hearings.

For the institutions, medical clinics, management personnel, professionals and physicians called upon to network.

Interactive forum on service integration

Some of the objectives submitted for consultation are aimed at mobilising partners, encouraging their support and strengthening their commitment. This being said, several of the actions that the plan entails will require not only their commitment, but also networking on their part to ensure the continuity and optimisation of services offered by various partners to a single clientele, or to resolve complementary issues. This joint action is particularly significant in the sectors of physical health, services for young people, and mental health.

Procedure

Care providers from various institutions who have a decision-making role, or are professionals who are directly concerned by the development of integrated service networks, will be invited to participate in a day of consultation. They will be provided with a participation booklet containing improvement proposals and case histories, aimed at guiding reflection. The participation booklet will contain continuity themes drawn from the draft 2003-2006 Strategic Plan, and will feature case scenarios developed with the participation of physicians and professionals in institutions to illustrate the themes.

During the event, participants will be invited by sector of interest (physical health, youth, mental health), to discuss one or more relevant cases (a number of small groups, to be determined according to the overall number of participants), to draw conclusions and formulate recommendations. Each sector will have its own mini-plenary so that the participants concerned can vote interactively on service integration.

A plenary session at the end of the day will make it possible to identify similar or converging ideas that can be taken on board to improve the proposed solutions for improving service integration.

Time and place

April 2nd, 2003
9:00 am to 5:00 pm

Renaissance Conference Centre, Boticelli Room - 7550, Henri-Bourassa Blvd. East, Montreal (Quebec)

For representatives of the users committees of youth centres, residential and long-term care centres, rehabilitation centres, CLSCs and hospitals.

Users committee consultation forum

There are 114 users committees in the Montreal health and social services network. The representatives of these committees will be consulted on the proposals contained in the consultation paper for the Montreal Improvement Plan for Health and Well-Being 2003-2006 during a half-day forum. This familiar format has proven effective in meeting the expectations of those invited to attend, and makes it possible to discuss proposals in a context that is conducive to an exchange of views.

Procedure

The presidents of users committees will receive the consultation documents and questionnaires on the proposals requiring reflection, along with their invitation to participate in the Consultation Forum. The persons delegated to represent each committee must register in advance with the Regional Board. Workshops will be followed by a plenary, during which participants' recommendations will be pooled.

Time and place

March 31st, 2003
9:00 am to 2:00 pm
Holiday Inn Select Hotel, Ballroom - 99 Viger Avenue West, Montreal (Quebec)

For executive directors, the presidents of boards of directors, and management teams.

Sub-regional meetings

Before the start of consultations, the President and Executive Director met with the executive directors and management teams of institutions. A second day of meetings will make it possible to inform institutions of the major trends that emerged during the consultation and exchange process, in an inter-institutional context, regarding the 2003-2006 Strategic Plan.

Time and place

These meetings will be held in an institution within each of the sub-regions. Dates will be determined.

For executive directors, professional service directors and service directors.

Thematic workshop on human ressources availablility

Will we be able to achieve the objectives we have set, given the physical and human resources currently at our disposal in Montreal?

This workshop is aimed at consulting actors in the field of human resources, particularly institution managers, about the regional proposals involving human resources. The goal here is to find solutions that will improve the health of our organisations in terms of human resources. The proposals under consideration will deal with issues such as the organisation of work, management of work attendance, and the availability of human resources in Montreal.

Procedure

Participants in this workshop will be invited by the Regional Board to speak out, in small groups, on the proposals contained in the "*Action for Health*" document, and to suggest the best potential solutions to ensure sufficient, available staffing, and improve the health of our organisations when it comes to human resources.

Time and Place

April 4th, 2003
9:30 am to 3:00 pm
Holiday Inn Select Hotel, Ballroom - 99 Viger Avenue West, Montreal (Quebec)

For members of the Montreal Public Health Partners Forum

Montreal Public Health Partners Forum

The Montreal Public Health Partners Forum, created by the Conseil régional de développement de l'Ile de Montréal (Regional Development Council for the Island of Montreal - CRDIM) and the Department of Public Health, represents the various milieus created by the CRDIM colleges, which include representatives of groups that are key to achieving the objectives of the Montreal Public Health Action Plan. One of the Forum's mandates is to carry out the inter-sectoral communication and mobilisation strategies needed to develop, implement and follow-up on the Montreal Public Health Action Plan. Furthermore, as part of the consultation and participation initiative, the Forum will sponsor a three-phase consultation on the Montreal Public Health Action Plan.

1. The first phase of consultation is comprised of thematic workshops dealing with the axes for intervention defined in the public health action plan. Members of the Forum are asked to participate in exchanges of views and debates on the chosen themes, to ensure that partners are mobilised and united behind these issues.
2. The public hearings and presentation of written submissions organised by the Regional Board as part of its consultation process will be the second consultation phase. The organisations represented within the Montreal Public Health Partners Forum may, if they wish, present a written submission on the proposals arising from the consultation paper for the Montreal Public Health Action Plan or the Montreal Improvement Plan for Health and Well-Being.
3. The final phase of consultation will be in the form of a regional meeting, with the participation of Montreal Public Health Partners Forum members, aimed at tying together everything discussed during the previous two consultation phases. Once consultation has been completed, The Montreal Public Health Partners Forum will send its report to the Planning and Evaluation Committee of the Board of Directors of the Regional Board.

For network leaders and regional partners, such as school boards, colleges, universities, expert groups and the City of Montreal.

Bilateral information and consultation meetings

The President and Executive Director of the Regional Board will organise information meetings with key partners to inform them about major trends in regional strategic planning.

These meetings will give participants the opportunity to give their opinion on the Montreal Public Health Action Plan and the Montreal Improvement Plan for Health and Well-Being. This initiative is aimed at facilitating and encouraging fruitful partnership agreements between the Regional Board and its partners.

Procedure

The President and Executive Director will request a meeting with the leaders of different milieus to present the Strategic Planning process and issues. A second meeting will be organised subsequently to hold a more specific discussion on objectives, actions and ways of cooperating.

For network employees, physicians and all interested persons.

Des moyens électroniques de consultation

All consultation documents, as well questionnaires for collecting good ideas and comments will be accessible on the Regional Board's Website at **www.santemontreal.qc.ca**

All submissions sent in by individual Montrealers will be forwarded to the People's Forum to be taken into account in the preparation of its submissions.

SUMMARY TABLE OF CONSULTATION ACTIVITIES REGARDING THE MONTREAL IMPROVEMENT PLAN FOR HEALTH AND WELL-BEING 2003-2006

ACTION FOR HEALTH

Participants	Activities	Places	Dates (2003)
> Groups representing the population > Individual Montrealers	Written submissions Public hearings	Holiday Inn Midtown Hotel, 420 Sherbrooke Street West, Montreal (Quebec) Ambassador Room	April 22nd, 23rd and 24th, from 9:00 am to 9:00 pm
> Community organisation groupings > Regional unions, regional medical associations, institution groupings and socioeconomic organisations	Written submissions and public hearings Bilateral meetings	Holiday Inn Midtown Hotel, 420 Sherbrooke Street West, Montreal (Quebec) Ambassador Room	April 22nd, 23rd and 24th, from 9:00 am to 9:00 pm
> CRDIM Partner's Council members	Thematic workshops	Centre St-Pierre 1212 Panet Street Montreal (Quebec)	March 11th, 12th, 19th and 26th
	Public hearings	Holiday Inn Midtown Hotel, 420 Sherbrooke Street West, Montreal (Quebec) Ambassador Room	April 22nd, 23rd and 24th
	Meeting		Early May
> Members of the regional commissions involved (CMR, CIR, CMUR) > Members of the People's Forum	Information and consultation meetings	Regional Board	Mid March
> City of Montreal > University milieu and groups of experts > Education milieu	Bilateral information and consultation meetings	Regional Board or hosted by partners	February-March
> Network employees	Electronic means of consultation Written submissions	By e-mail www.santemontreal.qc.ca	
	Interactive Forum *Integrating services: physical health, mental health, young people*	Renaissance Conference Centre 7550, H.-Bourassa Ave. E. Montreal (Quebec) Boticelli Room	April 2nd 9:00 am to 5:00 pm
> Network managers (executive directors, professional service directors, service directors)	Thematic workshop on human resource availability	Holiday Inn Select Hotel 99 Viger Avenue West Montreal (Quebec) Ballroom	April 4th 9:30 am to 3:00 pm
> Representatives of the users committees of residential and long-term care centres, youth centres, rehabilitation centres, CLSCs and hospitals	Users committee Consultation Forum	Holiday Inn Select Hotel 99 Viger Avenue West Montreal (Quebec) Ballroom	March 31st 9:00 am to 2:00 pm
> Institution managers and professionals, medical clinic physicians being asked to network, community organisations	Interactive Forum Integrating services: *physical health, mental health, young people*	Renaissance Conference Centre 7550, H.-Bourassa Ave. E. Montreal (Quebec) Boticelli Room	April 2nd 9:00 am to 5:00 pm
> Executive directors, presidents of boards of directors, management teams	Sub-regional meetings	In an institution within each sub-region	To be determined

4.
Characteristics of the Montreal network

Mission

The Montreal health and social services network is comprised of over 140 institutions, 435 doctor's offices or medical clinics, and 530 community organisations funded by the Regional Board. Almost 90 000 persons work in the network every day, including 3 200 specialists, 2 190 general practitioners, 18 200 nurses, 1 200 social workers and 8 000 other professionals.

With an annual budget of nearly 4 billion dollars, this complex and diversified network must meet the equally complex and diversified health and social service needs of Montrealers. Given the presence of four major Quebec universities and several institutions with university teaching missions, the Montreal network also provides a wide range of ultra-specialised services to the population of other regions of Quebec, as well as a training environment for a significant proportion of the physicians and health professionals who work throughout Quebec.

In this context, the presence and leadership of the Montreal Regional Board is essential and indispensable to ensure the integration and continuity of services, as well as consistency in the interventions of the institutions, professionals, groups and organisations that provide services in Montreal.

With an operating budget that represents half of 1% of the regional budget, and given the responsibilities it shoulders with regard to governance of the health and social service network, here is the Regional Board's new mission statement, as well as its commitments toward achieving its mission.

Essentially devoted to improving the health and well-being of Montrealers, the Regional Board's mission is to:

- evaluate the population's health and well-being;
- identify needs and define the provision of services throughout its jurisdiction;
- initiate, guide and participate in prevention efforts;
- ensure the integration and consistency of services and care within its jurisdiction;
- facilitate access to services and the continuity of care;
- encourage popular participation in network management;
- support and coordinate the development of the various aspects of the university networks' missions;
- evaluate and report on the impact of interventions on the health of the population.

In fulfilling its mission, the Regional Board commits to:

- promoting the growth, empowerment and self-sufficiency of individuals and groups;
- acting with respect for the population, members of the network and its partners;
- working with the network and its partners;
- basing its decisions on its quest for equity and the collective good;
- show transparency and openness;
- recognising and encouraging the development of the skills of persons working within the network;
- optimising the use of the Montreal network's resources;
- supporting efforts for improvement, and the pursuit of excellence.

5.
Priorities for Montreal in 2003-2006

We propose to focus our efforts on six major priorities:

1. **Reducing the impact of social inequality on health through effective prevention activities**
2. **Acting in partnerships to find appropriate solutions to Montreal's social issues:**
   - young people with adjustment problems
   - violence
   - prostitution
   - homelessness
   - social housing
   - pathological gambling
   - alcoholism and addiction
3. **Developing a network of first-line services that is closely knit around family medicine groups (FMG)**
4. **Ensuring access to medical and hospital services within recommended timeframes:**
   - give Montreal a network for rapid access to diagnostic services, from 8:00 a.m. to 8:00 p.m., 365 days a year, 7 days a week
   - create designated centres for cataract surgery and hip and knee replacement
5. **Developing integrated service programs and networks for at-risk clienteles:**
   - elderly persons who are no longer self-sufficient
   - persons with chronic, progressive diseases (chronic obstructive pulmonary disease (COPD, heart failure, diabetes)
   - persons with cancer
   - persons with AIDS
   - persons with mental illness
   - persons with pervasive developmental disorders (PDD)
6. **Setting up regional service organisation plans in four priority sectors:**
   - residential and long-term care services
   - services for persons with physical impairments
   - services for persons with intellectual impairments
   - perinatal care services

We will specify the results expected in 2006 for each priority, and the proposed actions to achieve these results.

Financial needs are identified as recurring budget development, non-recurring costs, investments in capital expenditures or equipment, or indexed expenses linked to the yearly rise in the cost of health and social services, set at 2.6% in the ministerial action plan "*Pour faire les bons choix*" (Making the Right Choices).

Consultation on the priorities for Montreal in 2003-2006 is aimed at validating the relevance of the proposed priorities, the degree of importance that should be attributed to each priority, the value of targeted results, and our ability to achieve these results with the proposed activities and financial resources.

5.1 Reducing the impact of social inequalities on health through effective prevention activities

In order to reach this objective, we will adopt a Montreal Public Health Action Plan to be carried out from 2003-2006. This plan, *"Action for Prevention"* will include concrete steps to consolidate and develop effective measures to deal preventively with Montreal's most pressing health and social problems. We will work to improve Montreal's results in terms of health and well-being, documented in the Department of Public Health's 2002 annual report, *"La santé urbaine, une condition nécessaire à l'essor de Montréal"*. (Urban Health, a Prerequisite for a Booming Montreal).

The action plan proposes 16 objectives, clustered around six axes:

Axis 1: Reducing the impact of social inequalities on health, with a firm commitment to communities and living environments

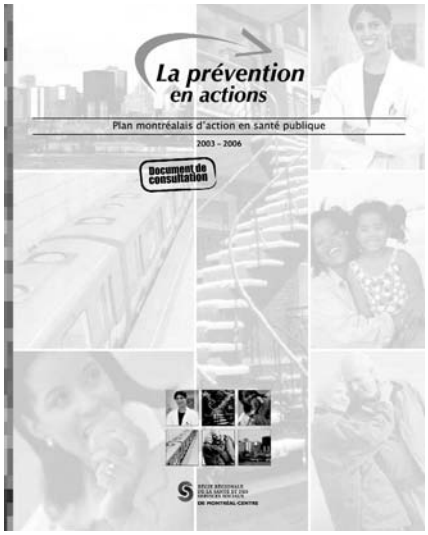
Axis 2: Integrating preventive measures into medical and professional practices

Axis 3: Reducing problems linked to the development, adjustment and social integration of children, young people, adults and the elderly

Axis 4: Preventing measurable-impact diseases and trauma

Axis 5: Concerted prevention and sanitary monitoring of real or perceived threats from biological, chemical or physical agents

Axis 6: More in-depth knowledge of the overall state of the population's health, and of its influencing factors



For more information, consult the document entitled "*Action for Prevention*" Montreal Public Health Plan.

The first two axes propose crosscutting strategies, whereas the other four put forth strategies that are specific to the following areas of public health: developing social adjustment and integration, living habits and chronic illnesses, unintentional trauma, infectious diseases, environmental health and occupational health.

The concern for reducing the impact of social inequalities on health is present in many of the actions proposed in the various axes. The priority given to this objective will take shape above all through the actions proposed in axis 1, which is devoted to it. Several of the projects put forth in axis 3 have to do with reducing the social adjustment and integration problems of children, young people, adults and the elderly, and will also contribute to reaching this objective.

AXIS 1: Reducing the impact of social inequalities on health, with a firm commitment to communities and living environments

The proposed actions are aimed at mobilising communities; creating environments that are conducive to good health; promoting healthy public policies, i.e., policies that foster better health, particularly through sustainable development for food security; developing communities; and fighting poverty.

AXIS 2: Integrating effective prevention measures into medical and professional practices

The proposed actions are aimed at equipping and supporting general practitioners, professionals in the CLSCs and

certain specialists to reinforce screening, health education and appropriate protection measures.

AXIS 3: Reducing problems linked to the development, adjustment and social integration of children, young people, adults and the elderly

The proposed actions are aimed at improving and integrating current programs to provide intensive support to mothers, fathers and children (ages 0-5) who are in at-risk situations (extreme poverty, limited schooling, young mothers, new immigrants). There is also a need to continue working with policymakers and municipal decision-makers to fight poverty.

The proposed actions focus simultaneously on a numbers of strategies to improve the mental health of adults: enhancing recognition of the early signs of trouble, and improving preventive clinical practice for persons in distress and family caregivers by better integrating the full range of services (first-line, secondary and tertiary care) and by facilitating immigrants' access to these services.

The proposed actions are aimed at promoting, in co-operation with municipal authorities, appropriate environments (adapted and accessible housing and transportation, safe and user-friendly urban planning, etc.) that will foster the participation and social integration of elderly persons, prevent exclusion and delay the loss of self-sufficiency.

AXIS 4: Preventing measurable-impact diseases and trauma

The proposed actions are aimed at encouraging healthy living habits by creating healthier living environments, particularly through concerted policies that support health-conscious eating habits and exercise, through better non-smoking strategies, and through the widespread implementation of activities to prevent falls and injuries among the elderly population.

AXIS 5: Concerted prevention and sanitary monitoring of real or perceived threats from biological, chemical or physical agents

The proposed actions are aimed at dealing with emergency situations, of an ordinary or exceptional nature, that are likely to have a major health and social, organisational or economic impact. Other actions aim to promote prevention and safe-sex initiatives aimed at reducing diseases that are transmitted sexually or through the bloodstream, and to improve access to the continuum of services by the segments of the population that are the most at risk.

The proposed actions are aimed at consolidating occupational health services, particularly to support preventive clinical practices to deal with occupational injuries, and to respond to an emerging issue: mental health problems.

The proposed actions are aimed at encouraging decision-makers to adopt concerted policies to improve the sanitary conditions of housing and of institutional environments (schools, hospitals), to reduce atmospheric emissions from stationary and moving sources, to control ragweed and to define strategies to adapt to climate change.

AXIS 6: More in-depth knowledge of the overall state of the population's health, and its influencing factors

The proposed actions are aimed at ensuring greater access to relevant data; to produce and analyse data and disseminate it to decision-makers and various partners to help them make informed choices, and assess the impact that the organisation of first-line services has on the population's health.

Generally speaking, the Montreal Public Health Action Plan aims to achieve the following targeted results, and requires the implementation of the proposed actions.

Targeted results

- Reduced impact of social inequalities on health.
- Improvement of the health and well-being results observed in the Department of Public Health's 2002 annual report, "*Urban Health*".

Proposed actions

- Optimise the use of current resources amounting to $55.6M earmarked specifically for prevention and public health in Montreal.
- Integrate prevention into the routine activities of network physicians, personnel and institutions.
- Consolidate and develop, at the required level of intensity, preventive activities that are recognised as effective. Some initiatives will be carried out by the network, and others will be implemented jointly with our main public health and prevention partners (the City of Montreal, schools, the United Way and various foundations, community organisations).
- Foster links between the strategic plans of Montreal's main actors in terms of social development, the struggle against social inequality, persistence in school, school success and dropout prevention support:
  - The Regional Board's 2003-2006 Strategic Plan
  - The City of Montreal's social development plan, and City Contract
  - The school boards' strategic plans and Action Plan for persistence in school, school success and dropout prevention support.
- Formulate and implement a local public-health action plan for every CLSC territory.

Carrying out these actions will require additional funds of $42M to be distributed in the following manner among the six axes of the Montreal Public Health Action Plan.

Additionnal financial resources required

5.1 Reducing the impact of social inequalities on health through effective preventive action

	NEEDS (M$)			
	Recurring	Non-recurring	Capital expenditures	Indexation
Axis 1: Reducing the impact of social inequalities on health, with a firm commitment to communities and living environments	3.1			
Axis 2: Integrating preventive measures into medical and professional practices	2.8			
Axis 3: Reducing problems linked to the development, adjustment and social integration of children, young people, adults and the elderly	23.6			
Axis 4: Preventing measurable-impact diseases and trauma	2.8			
Axis 5: Concerted prevention and sanitary monitoring of real or perceived threats from biological, chemical or physical agents	9.2			
Axis 6: More in-depth knowledge of the overall state of the population's health, and of its influencing factors	0.5			
Total	**42.0**			

For more details, see Appendix I of Support Document.

5.2 Acting in partnerships to provide appropriate solutions to Montreal's social problems

In Montreal, as in most big cities, we are faced with particularly intense and complex social problems, caused by:

- socio-economic rifts and more striking social inequalities;
- solitude and social isolation on the part of a growing segment of the population;
- the fragility of the social fabric surrounding many at-risk persons, namely young children and elderly persons who are no longer self-sufficient in some neighbourhoods.

These problems are in fact so significant and complex in Montreal, that the fight against poverty, exclusion and social inequalities was one of the priorities of the City Contract between Montreal and the Government of Quebec.

Even though Montreal is a development pole that contributes 50% of Quebec's total wealth and represents nearly half of the province's jobs, it is also characterised by social inequalities and the risk of exclusion for part of its population. The decay of certain neighbourhoods, pinpointed on the map produced by the City of Montreal and in the Department of Public Health's 2002 annual report, "Urban Health", accentuates the social problems we face:

- difficult social and workforce integration for certain categories of persons, including young people, immigrants and members of visible minorities;
- impoverishment of persons living alone, single-parent families and young children;
- homelessness;
- shortage of affordable housing.

5.2.1 Young people

Promoting the development and social adjustment of young people remains one of Montreal's greatest challenges. Most indicators linked to child and adolescent development show that problems in Montreal are more severe than elsewhere in Quebec.

Furthermore, these problems are concentrated in the priority intervention zones identified by the City of Montreal and the Government of Quebec. This concentration is obvious, be it in the variation in teenage pregnancy rates throughout the city, or in the rate of victimisation, abuse and neglect suffered by young people.

Fifty (50) of Montreal's 125 high schools have some of Quebec's highest indicators of deprivation.

With regard to interventions and services for young people, it is clear that:

- effective prevention programs are neither intensive nor accessible enough;
- inter-sectoral strategies need to be simplified, and better articulated in areas commonly recognised as priorities by the City, all government departments, the school boards and the United Way;
- basic services are not sufficiently developed in the CLSCs;
- services are difficult to co-ordinate when they are not clearly under the jurisdiction of CLSCs or youth centres, or of addiction, intellectual impairment, physical impairment or mental health institutions;

- waiting periods for access to specialised youth-protection needs assessment services are better than the provincial average, but fall short of national objectives;
- the effectiveness of intervention strategies must be evaluated on an ongoing basis.

In order to support the development, adjustment and social integration of young children and young people, we propose, within the context of our public health action plan, to undertake the following actions:

Targeted results

- Fewer development and social adjustment problems affecting children who live in a context of poverty.

Proposed actions

Promoting the development and social adjustment of young children

- Implement, in all 29 CLSC territories, the integrated perinatal and early childhood promotion and prevention program for pregnant women, mothers, fathers and children living in extreme poverty, while maintaining an overall health approach.
- Work to improve families' living conditions (food security, social development, housing, access to income, education and jobs), particularly with the CLSCs, the City and community organisations.
- Support physicians' preventive clinical practices, such as the promotion of breastfeeding, counselling on healthy living habits (tobacco and alcohol) and early stimulation of young children.
- Promote interventions for the early stimulation (motor, language, cognitive and social skills) of young children, in conjunction with the CLSCs and community organisations, and in co-ordination with childcare services (like the Fluppy program).
- Support breastfeeding, particularly by setting up the Baby Friendly network in the maternity wards of hospital centres, CLSCs and Birthing Centres.

Targeted results

- Fewer social adjustment problems among young people.
- Fewer teenage pregnancies.
- Fewer suicides among young people.
- Restricted access to alcohol for young people under the age of 18.

Proposed actions

Promoting the development and social adjustment of young people

- Reduce young people's adjustment problems:
  - implement, throughout the 29 CLSC territories, local, inter-sectoral plans based on strategies for the development of personal and social skills in the school environment, intensive support of at-risk young people, parental support, and the creation of environments that foster health and well being.
  - implement in the school environment, in conjunction with the CLSCs, programs aimed at young people and their parents targeting persistence in school, the promotion of mental health, adjustment to transition phases, skill development and the prevention of violence, games of chance and gambling (e.g., school support programs, intervention tools like *Le Sac à dos [Teen Back Pack], Un double saut non périlleux [On Firm Ground], Contes sur moi [All About Me], and VIRAJ, un programme qui vise la prévention de la violence dans les relations amoureuses [PAVIR, Program Against Violence in Relationships]* , etc.);
  - continue implementing programs aimed at developing the employability, participation and social integration of young people (such as *Pères et insertion [Including Fathers], Freiner la marginalisation [Putting the Brakes on Marginalisation]*, etc.)
  - promote access to programs and interventions for young people from immigrant communities.
- Decrease the number of teenage pregnancies:
  - establish and monitor the teenage pregnancy profile;
  - improve access to clinical services (e.g., youth clinics), emergency oral contraception and free services for voluntary termination of pregnancy;
  - support the development of preventive clinical practices (e.g., information and counselling on sexuality);
  - strengthen integrated prevention approaches.
- Reduce the suicide rate:
  - establish and monitor the suicide profile of young Montrealers;
  - share knowledge to consolidate integrated prevention initiatives on CLSC territories, in conjunction with youth centres;
  - continue working with regional partners (*Table de concertation en prévention des suicides* - Suicide Prevention Co-ordinating Group) to improve preventive clinical practices, such as protocols for evaluation and follow-up of young people who are at risk.
- Promote health-oriented public policies:
  - support influential actions, such as the promotion of laws and regulations, to restrict access to alcohol by people under the age of 18.

Targeted results

- Ensured follow-up by the CLSCs of the 4 800 or so young people whose cases are reported to, but not taken on by the Department of Youth Protection every year.
- Integrated services for young people who need the expertise of various institutions and partners.
- A maximum delay of 15 days between the time a youth protection case is reported and evaluated.

Proposed actions

Organising services for young people

- Set up a single port of entry for receiving, evaluating and referring requests for psychosocial services for children, young people and families, and consolidate basic services in Montreal's 29 CLSCs.
- Set up a locally based, local youth intervention team, with partners from the network.
- Set up crisis intervention and intensive follow-up services, assigning certain CLSCs the role of providing services on a sub-regional basis.

  Evaluations have shown the effectiveness of these teams, which intervene quickly and intensively with young people, their families and their environment to defuse crises and find alternatives to foster care by mobilising relevant resources in the community.
- Use management agreements to ensure the mobility of the resources required to decrease waiting times for access to youth protection services, which are currently 19 days in Montreal Youth Centres, and 17 days at the Batshaw Centre.
- Ensure mobilisation of the resources required to decrease waiting times for psychosocial expertise services in the Superior Court, by making optimum use of the budgets already allocated for this purpose.
- Develop more places in intermediary and family-type resources to meet the needs of young people with mental disorders.
- Promote the systematic use of intervention plans and personalised service plans.
- Apply the national training plan in CLSCs and youth centres to decrease recourse to foster care, and shorten stays in placement.
- Develop programs for the social integration of young people age 16 and up, as well as agreements and specific projects to meet the various needs of children, young people and families, in co-operation with inter-sectoral partners.

There is a growing demand for child psychiatry services, particularly from network partners like youth centres and CLSCs. The 10 hospitals that provide these services for the Montreal and Laval areas must deal with the constant increase in demand, paired with a shortage and dwindling numbers of child psychiatry personnel. Furthermore, there is a net growth in the use of Montreal's services by neighbouring areas, which adds to the case overload.

First-line mental health services for young people are virtually non-existent. While some interventions are carried out on the front line, they are far too few; as soon as a case becomes complex, there is a tendency to refer quickly to secondary services, or even to use hospital emergency departments to obtain faster access to services. It is also common for young patients to be referred directly to child psychiatry without preliminary evaluation, which adds to the overloading of child psychiatry services.

There is considerable compartmentalisation and a lack of functional ties between child psychiatry services and health and social service network institutions and professionals who work with children and young people. Finally, placement resources and youth centres are not accessible enough to young people with particularly severe conditions. This situation leads to prolonged hospitalisation of these young people, even after their release has been authorised. Hospitalisation is therefore often used as a placement alternative.

Targeted results

- Availability of one child psychiatrist and three professionals for every 10 000 young people in every sub-region.
- Child psychiatry services provided to young people in youth centres by designated hospitals.
- Basic mental health services for young people at all CLSCs.

Proposed actions

Organising child psychiatry services

- Designate three groupings of child psychiatry services and departments (East, West and North-Centre) and assign sector (outpatient clinic) and sub-regional (emergency, hospitalisation and day hospitals) mandates to each child psychiatry service grouping.
- Following consultation, choose a scenario to achieve this purpose that reflects the principles described in Appendix 3 of Support Document.
- Formulate plans for the organisation of child psychiatry services, as well as child-psychiatrist and other professional resource staffing plans for each grouping, so that they can fulfil their sectoral and sub-regional mandates.
- Assign a regional mandate for consultation, evaluation/diagnosis and treatment services for the clientele of young people placed in youth centres.
- Set up, within each youth centre (Montreal, Batshaw and Laval), a mental health support team that will liaise with the designated child psychiatry service or department.
- Ensure the presence of a pivotal care-provider linked to the delivery of mental health services in every CLSC, who will liaise with teams in outpatient child psychiatry clinics.
- Develop a training program in youth mental health for service providers in CLSCs and youth centres.
- Implement a liaison/consultation mechanism between the teams in child psychiatry outpatient clinics, CLSC teams and youth-centre territory teams.
- Develop a child psychiatry referral tool for CLSCs and youth centres.

5.2.2 Montreal's social problems

While placing a very high priority on the development, adjustment and social integration of Montreal's children and young people, we must act with our principal partners to identify and apply the best possible solutions to Montreal's social problems. These problems - homelessness, prostitution, conjugal violence, sexual assault, pathological gambling, alcoholism, addiction - are often interrelated and affect the persons in question and their family and friends in various ways. The Conseil québécois de la santé et du bien-être (Health and Welfare Council) has confirmed the outstanding incidence of social problems in the Montreal area, compared to the rest of Quebec. These interrelated social problems are particularly acute in downtown Montreal.

Targeted results

- Improved social integration and service co-ordination for young people on the streets, the homeless and street prostitutes.
- Improved access to fast referral services in crisis situations for the victims of conjugal violence and aggressive spouses, as well as for the victims of sexual assault.
- Improved access to treatment and support services for gamblers in trouble and their families, in their own environment.
- 500 social housing units with community support.

Proposed actions

Homelessness

- Reduce the incidence of homelessness by preventing the marginalisation and social exclusion of young people:
  - consolidate clinical services for young people in the streets;
  - develop and disseminate a tool to identify clienteles that are at risk of becoming homeless, and intervene as early as possible;
  - consolidate community residential resources for young people with adjustment problems through additional recurrent funding.
- Ensure that the health, social service and shelter needs of homeless persons are met on a permanent and ongoing basis:
  - develop, by September 2003, an inter-sectoral action plan to deal with homelessness, and sign a memorandum of understanding with the City of Montreal;
  - increase the number of places in emergency shelter facilities during the cold season;
  - consolidate the services of the CLSC des Faubourg's Homelessness Team;
  - set up a service to deal with social emergencies and co-ordinate services that will be accessible 24 hours a day;
  - consolidate the services provided by community organisations that provide shelter.

Proposed actions (continued)

Prostitution

- Mitigate the harmful effects of street prostitutes' difficult living conditions by improving the services at their disposal:
  - access to basic and emergency services;
  - access to prevention programs and appropriate services.

Social housing

- Make social housing the cornerstone of initiatives for the integration of persons with multiple problems:
  - implement the memorandum of understanding between the Regional Board, the City of Montreal, the Société d'habitation du Québec (Quebec Housing Corporation) and the ministère des Affaires municipales et de la Métropole (Department of Municipal Affairs and the Metropolis) on funding for community support of social housing for the homeless;
  - ensure the funding required to set up the community support services needed to make all of the planned 500 units of social housing a reality.

Violence

- Strengthen the continuum of services to deal with conjugal violence:
  - intensify appropriate screening and referral activities for persons affected by conjugal violence, with particular attention to those who are the most at risk: children exposed to conjugal violence, young parents, elderly persons who are no longer self-sufficient;
  - intensify rapid response in crisis situations (24-48 hours after the assault) for victims and attackers;
  - consolidate and develop basic services for women who are victims of conjugal violence, children exposed to conjugal violence, and attackers.
- Strengthen the continuum of services to deal with sexual assault:
  - consolidate and develop activities linked to the screening and proper referral of sexual assault victims;
  - improve intervention in crisis situations;
  - consolidate the basic services available for victims and attackers.

Pathological gambling

- Develop and implement a regional strategy to promote responsible gambling and prevent pathological gambling.
- Develop tools to provide information and raise awareness about the risks associated with pathological gambling, and protection factors.
- Equip every CLSC with a screening and short-term intervention program for at-risk persons, as a complement to early screening and intervention services for alcoholism and addiction.
- Give gamblers in trouble and their families access to a continuum of integrated services: reception, evaluation, referral, treatment, support, and social re-integration.

5.2.3. Alcoholism and addiction

We propose to undertake the following actions to supplement the network of alcoholism and addiction rehabilitation services by 2006.

Targeted results

- A prevention program in all Montreal CLSCs.
- An increase in the places available in detoxification centres, from 49 to 69.
- Increased access to methadone maintenance treatment.

Proposed actions

- Intensify actions upstream from social adjustment problems and prevent the exacerbation of problems linked to the use of psychotropic substances:
  - draft and disseminate an annual report on the epidemiology of addiction in Montreal;
  - revise the regional prevention program and make it more widespread by extending it from 16 to 29 CLSCs;
  - support and fund preventive intervention in high-risk environments (e.g. rave parties);
  - intervene with heavy drinkers by supporting the regional Alcochoix (Alcochoice) program.
- Improve first-line screening and early action:
  - encourage training on the part of service providers in youth centres on ways to deal with addiction;
  - make screening and early intervention services available in the CLSCs;
  - integrate addiction intervention into the "*Soutien aux jeunes parents*" (Young Parent Support) program.
- Provide a full range of specialised services and promote the social integration of persons who are addicted to drugs:
  - increase the number of places in detoxification centres from 49 to 69;
  - consolidate inpatient services for English and French-speaking young people;
  - develop specialised services for persons suffering from mental health problems linked to addiction;
  - consolidate the training and expertise services of the Cormier-Lafontaine clinic;
  - offer addiction services to persons who are subject to judicial control, to help courts direct persons who are addicted to drugs;
  - develop addiction services in Montreal's three custodial facilities;
  - create intermediate resources for the placement of elderly persons who are addicted to drugs.
- Extend access to methadone maintenance treatment services:
  - ensure recurrent funding and consolidate methadone maintenance treatment services;
  - support CLSC teams by ensuring that physicians, nurses and social practitioners are trained to take care of adequately controlled patients;
  - support methadone maintenance treatment at Montreal's custodial facility.
- Ensure that cocaine addicts have access to appropriate services:
  - set up a multidisciplinary team to provide appropriate services to this clientele;
  - carry out a feasibility study on the implementation of assisted injection sites to prevent the spread of infectious diseases (HIV, HCV).

Additionnal financial resources required

5.2 Acting in partnerships to provide appropriate solutions to Montreal's social problems

		NEEDS (M$)			
		Recurring	Non-recurring	Capital expenditures	Indexation
5.2.1	Young people	20.0			
5.2.2	Urban social problems	6.6			
5.2.3	Alcoholism-addiction	5.1			
TOTAL		**31.7**			

It will take an additional $31.7M in recurring funds by the year 2006 to carry out the measures put forth for this priority.

These measures will enable us to complete the work already underway thanks to additional budgets we received this year:

- $4M for the Young Parent Support Program
- $2.5M to improve first-line services for young people between the ages of 6 and 17.

5.3 Developing a network of first-line services that is closely knit around Family Medicine Groups (FMG)

Our third priority is to develop a territory-wide network of first-line medical and psychosocial services that:

- will be accessible 24 hours a day/7 days a week;
- will guarantee the continuity of services;
- will ensure the case management of at-risk clienteles: elderly persons who are no longer self-sufficient, persons with chronic progressive diseases (lung disease, heart failure, diabetes), persons with mental health problems, persons who need palliative care.

5.3.1 Implementing 58 Family Medicine Groups (FMG) by 2006

Setting up 58 FMG in the space of three years, which represents an average of two groups per CLSC territory, would pave the way for case management of between 700 000 and 870 000 people, i.e. 39 to 48% of the Montreal population.

Targeted results

- The presence of 58 Family Medicine Groups (FMG).

Proposed actions

- Ensure the start-up and recurrent funding of FMGs via an initial investment of $29M and an annual injection of $34.8M.
- Ensure the recruitment of 116 nurses by CLSCs and FMGs.
- Ensure electronic liaison between FMGs and CLSCs, diagnostic resources (laboratories, radiology services) and hospitals.
- Ensure mobility toward the FMGs of between 464 and 580 of the 1 145.2 general practitioners providing first-line medical care in Montreal, to cover 40 to 50% of staffing. This represents 26 to 33% of the 1 747.4 EFT general practitioners currently in clinical practice.

5.3.2 Providing standardised services in all CLSCs, accessible 7 days a week, for a total of 80 hours

Targeted results

- Nursing and psychosocial services available 7 days a week in all CLSCs.
- Sample collection services without an appointment, available 7 days a week in all CLSCs.
- Access to all CLSCs, 80 hours/week.
- Access to Info-Santé (health information hotline) in under 4 minutes.
- Psychosocial care incorporated into Info-Santé.

Proposed actions

- Ensure 80 hours of reception, evaluation, referral and treatment services in the areas of nursing and psychosocial services, including transient mental health problems.
- Equip all CLSCs with sample collection services without an appointment.
- Ensure 24-hour on-call nursing services for at-risk clienteles.
- Reduce waiting times for Info-Santé telephone services: process 90% of calls in less than 4 minutes.
- Complement the Info-Santé service with a 24-hour Info-Social hotline for persons with psychosocial problems.

Additionnal financial resources required

5.3 Developing a network of first-line services that is closely knit around Family Medicine Groups (FMG)

		NEEDS (M$)			
		Recurring	Non-recurring	Capital expenditures	Indexation
5.3.1	Implementing 58 Family Medicine Groups (FMG)	34.8		29.0	
5.3.2	Providing standardised services in all CLSCs, accessible 7 days a week, for a total of 80 hours	30.0			
TOTAL		**64.8**		**29.0**	

5.4 Ensuring access to medical and hospital services within recommended timeframes

5.4.1 Emergency services

Reducing the overcrowding and length of stays in emergency rooms remains a priority for Montreal, where there is still a of work to do to reach set objectives.

In the case of emergency rooms, the diagnosis is still valid. The real issue is to create the capacity to implement the solutions needed upstream from emergency rooms, in hospitals, and downstream from emergency rooms and hospitals.

The conditions for success seem to have improved:

- Agreements with physicians to set up the Family Medicine Groups (FMG).
- Available funding to launch and operate the groups, including nursing-service liaison with the CLSCs.
- The possibility of considerable additional funding for first-line services and for persons who are no longer self-sufficient.
- Negotiation of management agreements with the hospitals to decide on the amount of care expected, and priority objectives in relation to the resources granted.

These new elements lead us to propose the following actions to improve the situation in Montreal's emergency rooms.

Targeted results

- A 30% decrease in emergency room visits.
- Rapid access, first-line diagnostic services.

Proposed actions

Upstream from emergency rooms

- Set up a network providing rapid-access, first-line diagnostic services from 8:00 am to 8:00 pm, 365 days a year.

  In order to do this, we propose to designate 30 medical clinics, Family Medicine Groups (FMG) and CLSCs as rapid-access points of service that will be available without an appointment, from 8:00 am to 8:00 pm, all year long. We propose to designate some of these points of service to provide ultrasound services.

Targeted results

- Stays of over 48 hours cut from 9.8% to 0%

Proposed actions

In emergency rooms and hospitals

- Obtain a firm commitment from institutions to consider emergency rooms as their priority, and change hospital culture accordingly.
- Reach an agreement with hospitals, in the context of management agreements, on the volume of care expected in proportion to allocated resources, objectives to be reached in emergency and in optimum management of hospital beds.
- Designate certain emergency rooms for thrombolysis of patients who have suffered a cerebral vascular accident (CVA).
- Set up a non-recurring fund of $45M to make targeted adjustments (purchase places in rehabilitation or residential care) to the provision of services, in order to deal with seasonal changes in emergency-room overcrowding.
- Create a permanent bank that would make it possible to allocate additional presence days to hospitals, in relation to their progress toward achieving emergency-room objectives.
- Implement work reorganisation projects in all hospitals, aimed at achieving optimal use of human resources.

  It is important to show initiative in this area to bypass the effects of personnel shortages and deliver the required volume of services.

  It is furthermore a recognised fact that some persons perform tasks that could be performed by other categories of personnel. This situation has a negative impact on the motivation of employees who feel under-utilised. Structured actions to regain balance would result in increasing recognition of these persons and ensuring better use of their skills.

  The recent adoption of the new Act modifying professional codes (Act 90) opens up new possibilities in this respect, since it authorises certain categories of personnel to perform new tasks.

  The Régie régionale will continue to support concrete projects enabling institutions to review the roles of all care personnel, particularly the role of nurses, to ensure better utilisation of their skills. As part of this reorganisation, it is also important to focus on a strategy to equip the personnel with tools that accomplish more, taking advantage of the full potential of new technologies, particularly with regard to information systems, computer applications and automation.
- Review the provision of emergency services in West-Central and East-Central Montreal, in the context of the future CHUM and MUHC.

  Ultimately, the incorporation of the CHUM and the MUCH into unique centres at the cutting edge of technology, as required for the full realisation of their vocation as ultra-specialised care, teaching, research and technology evaluation centres, will lead to an increase in the proportion of tertiary and quaternary care provided in these new environments.

Proposed actions (continued)

This will also lead to a decrease at the CHUM and the MUHC of level 1 and 2 care that can be provided with quality and at a lower cost in most hospitals in Montreal and neighbouring regions.

The development of the CHUM and the MUHC toward an academic vocation oriented more and more toward the delivery of ultra-specialised care, teaching, research and the evaluation of technologies will lead, in those environments, to emergency rooms with an academic and local vocation, rather than emergency rooms that treat a large flow of patients.

Consequently, in order to improve the performance of Montreal's network of emergency services, and to be able to deal with the foreseeable volume of emergency visits (currently 681 952 per year in general emergency rooms), with an 8% increase in patients on stretchers since 1997-1998, it will be necessary to keep:

- one 350-bed hospital in East-Central Montreal, with a major emergency room open to the community and with the capacity to receive 75 000 visits per year;
- one 268-bed hospital in West-Central Montreal, also with a major emergency room capable of receiving 57 000 visits per year.

Once adopted, this orientation will make it possible to recalibrate the contribution expected from other services within the Montreal emergency service network and define, in a precise manner, the mission and contribution of the emergency rooms that will be built in the new buildings of the CHUM and the MUCH. This will also make it possible to move quickly to make the right decisions concerning hospitals and emergency rooms currently located downtown, particularly with regard to capital expenditures and equipment.

With this in mind, for the short term, we could give two other hospitals in Central, Northern or Eastern Montreal the principal mission of providing emergency services, thus decreasing the pressure of demand on the university centres.

- Ensure the implementation, in all emergency rooms, of an information system that would enable monitoring and analysis of services, and facilitate the process of identifying corrective measures required in the short, medium and long term, based on conclusive data.
- Collaborate with university research groups on emergency services to find ways of:
  - facilitating access to data relevant to applied research on emergency services and on the evaluation of planned or actual measures to improve the performance of emergency rooms;
  - better integrating and synthesising conclusive data and information on emergency rooms;
  - making decisions based on available knowledge and supported by conclusive data;
  - facilitating the integration of data required to study emergency-related phenomena;
  - exploiting the full potential of emergency-related information systems.
- Retrofit and enlarge 10 emergency rooms as needed.

Downstream from emergency rooms and hospitals

- Increase home care services and residential care services in the community for elderly persons who are no longer self-sufficient.
- Increase access to palliative care at home.
- Develop postoperative care and rehabilitation at home.
- Speed up access to rehabilitation services.

Projects to retrofit 10 emergency rooms: +68 stretchers

Hospital	Capital expenditures ($M)	Additional Performance Budget ($M)	Steps for completion
Maisonneuve-Rosemont Hospital	32.0	2.350	Design concept submitted and requiring a budget increase by the Ministry
Sacré-Coeur de Montreal Hospital	25.7	0.570	Design concept submitted and under analysis; changes to basement being considered
Santa Cabrini Hospital	22.7	0.380	Design concept approved and requiring a budget increase by the Ministry to proceed
Verdun Hospital Centre	13.1	0.171	Preliminaries accepted with recommendation of a budget increase and order issuance
Ste-Justine Hospital	9.2	0.184	Project with performance order - definitive plans and specifications underway
Hôtel-Dieu of the CHUM	3.4	- - -	Underway - envelope closed
Montreal Cardiology Institute	16.9	- - -	Recommended - regional capital expenditure priorities for 2002-2003 awaiting consideration
Lachine Hospital Centre	1.0	- - -	Recommended- regional capital expenditure priorities for 2002-2003
Fleury Hospital Centre	2.0	- - -	Recommended- regional capital expenditure priorities for 2002-2003
Jean-Talon Hospital	1.6	- - -	Recommended- regional capital expenditure priorities for 2002-2003
TOTAL	**127.6**	**3.655**	

5.4.2 Ensuring access to specialised medical services within clinically recommended timeframes

A second priority in terms of access to specialised medical services is to ensure that patients receive the treatment they require within recommended timeframes.

Targeted results

Shorter access times for specialised services

Cardiology	- haemodynamics:	< 1 month
	- electrophysiology:	< 3 months
	- cardiac surgery:	< 3 months
Oncology	- surgical oncology:	< 1 month
	- radiation oncology:	< 3 months
Orthopaedics	- hip and knee replacement:	< 3 months
Ophthalmology	- retinopathy:	< 1month
	- cataract surgery:	< 6 months

Proposed actions

- Grant additional targeted funding to bring the waiting list in line with desired waiting times, and to finance the growth in demand between now and 2006, while respecting recommended access times.
- Designate **two cataract centres** in the hospital environment that would meet the following parameters:
  - an annual volume of 7 000 to 10 000 cases in day surgery for each centre;
  - all steps of the process would take place there: preadmission, surgery, post-operative care;
  - one of the centres would be connected to the McGill University network, and the other to the University of Montreal network;
  - satellite centres would be maintained to deal with overflow, if required.
- Concentrate **hip and knee replacement** activities and reorganise the continuum of services to:
  - increase the number of interventions to meet needs within established timeframes;
  - reduce average hospital stays for hip and knee arthroplasty to 7.3 days; they currently range from 7.4 to 13.2 days, depending on the hospital;
  - achieve a rate of 50% risk-free discharge home by 2005.
- Decide on a scenario for concentrating services in a limited number of hospital centres following a call for proposals to determine the best approach and obtain the most cost-effective service in a safe environment.
- Increase the volume of surgery by recovering surplus operating capacity available in certain hospitals.

  The hospitals where certain specialised services would be concentrated will be designated according to the principles recommended by the Regional Medical Commission in its December 2000 report on the organisation plan for the specialised medical services) (Appendix 4 of Support Document).

	Targeted volume increases by 2006	Forecast annual volume for 2006	Additional volume produced between 2003 and 2006	Expected cost of additional volume ($M) 2003-2006	Annual budget required in $M 2005-2006
Cardiac surgery and tertiary cardiology					19.3
Cardiac surgery:	+ 400	6 000/year	1 087	18.1	
Correction of under-funding				12.6	
Coronary stent	+ 541	9 372/year	1 075	1.2	
Haemodynamics - angioplasty	+ 1 320	22 885/year	3 416	7.3	
Defibrillators	+180	433/year	344	8.0	
Sub-total, cardiac surgery				**47.2**	
Orthopaedics: hip and knee replacement	+ 1 400	3 775/year	4 621	51.0	15.0
Ophthalmology: cataracts, retinopathy	+ 9 800	28 800/year	26 250	29.6	10.9
Haemodialysis (pre-dialysis treatment)	+ 36 000	225 000/year	70 753	15.1	7.2
Organ and other transplants	+ 30 kidney transplants	186/year	82.0	30.5	11.0
	+ 17 lung transplants	54/year	47.0		
	+ 15 liver transplants	105/year	42.0		
	+ 20 bone marrow transplants	226/year	54.0		
Neurostimulators	+ 25	45/year	70.0	1.1	0.4
Surgical oncology and radiation oncology				9.3	3.9
Medical imaging	+6 magnetic resonance imaging +2 positron emission tomograph (PET)			13.8	6.3
Expensive medication* and special programs*				3.9	1.6
TOTAL				**201.5**	**75.6**

Note: Expensive medication: cystamine, phenylbutirate, interferon Gamma IB, for example
Special programs: hemoglobine disease and thalassanemia, falciform anemia screening, adult congenital cardiopathy

Production of the additional volumes needed between 2003 and 2006 to ensure access to medical service within recommended timeframes will require disbursements of $201.5M during that period. Sustaining the production of volume reached in 2005-2006 will require an annual budget of $75.6M.

The indicated increases in volume are necessary to observe clinical timeframes and meet the demand in these areas on the part of the population of Montreal and other regions of Quebec.

Number and percentage of certain types of surgery performed in Montreal, according to patients' place of residence. Provided for two years (1999-2000 and 2000-2001)

Operation	Neighbouring regions		Other regions		Montreal		Total
	Nbr.	%	Nbr.	%	Nbr.	%	Nbr.
Angioplasty	5,005	46	1,611	15	4,246	39	10,862
Coronary bypass	3,433	50	973	15	2,421	35	6,827
Cataract	7,824	24	623	2	24,015	74	32,462
Knee implant	623	33	60	3	1,225	64	1,908
Hip implant	712	31	87	4	1,510	65	2,309
Total	**17,597**	**32,4**	**3,354**	**6,2**	**33,417**	**61,4**	**54,368**

Neighbouring regions : Laval, Laurentides, Lanaudière and Montérégie

In the case of angioplasty, 61% or interventions are performed on persons from other regions of Quebec. This percentage is as high as 65% for coronary bypass surgery. Even in the case of cataract surgery, 26% of interventions are performed on persons from neighbouring regions.

Given these characteristics, this type of priority requires a special approach in terms of funding. Two sources of funding are identified in the Ministerial Action Plan, "Making the Right Choices"

- A non-recurring envelope of $162M, to comply with access times for specialised medical services.
- An indexation rate of 2.6% to fund increases in costs specific to the health and social services sector.

Given the proportional needs of the population in Montreal and other regions with regard to access to these priority services provided in Montreal, we believe that $65M should be granted from the national fund for this purpose. Covering the balance would require allocating $136.5M over three years, disbursed on the basis of indexation of regional credits, i.e. $60.9M in 2004-2005 and $75.6M in 2005-2006.

However, one possibility that remains to be validated is that the planned concentration of services in ophthalmology and orthopaedics may lead to a drop in unit costs now estimated at $1 100 for cataract surgery, $11 000 for hip replacement and $10 600 for knee replacement. For example, over 3 years, a 10% drop in unit costs exclusively for expected additional volume represents savings of $3M. A forecast of unit cost savings on the total annual volume, forecast at 28 800 cataract operations in 2005-2006, would give recurring annual savings of $3.1M.

During the consultation period, we shall explore all avenues enabling us to decrease unit costs in these areas while maintaining service quality. This will make it much easier to produce the additional services required to meet demand within recommended timeframes.

5.4.3 Plan for organising specialised medical services and setting up the integrated university health networks

The proposed strategies to improve access to certain specialised medical services will lead us to reflect on the relevance of designating or concentrating certain services in two specialties: ophthalmology and orthopaedics. This reflection should take into account the overall organisation of these specialties in Montreal, interrelations with other specialties and their contribution to university networks. Similarly, proposals put forward to reorganise first-line medical services mean that we need to rethink the general practitioner-specialist interface within a network of accessible medical services in Montreal.

It seems better to deal with these issues within the framework of a comprehensive approach, rather than separately and without linking them to the development of the university networks and the upcoming projects involving the CHUM and the MUCH.

In just such a comprehensive approach, the Regional Medical Commission has adopted a report intended to guide the development of the Montreal Organisation Plan for Specialised Medical Services and Medical Staffing. In the report (see Appendix 4 of Support Document), which is part of the present consultation, the Medical Commission makes recommendations regarding important elements that could be used as the basis for formulating a regional plan for organising specialised medical services.

The current provisions of the Act respecting health services and social services stress the need to come up with an integrated process and plan for the organisation of specialised medical services if we want to adopt coherent staffing and organisation plans in all hospitals for the 34 medical specialties. The provisions to this effect in draft Bill 142 (2002, Section 66), adopted and ratified in December 2002, but not yet in effect, also lead in this direction.

These organisation and staffing plans will also have to be developed in university institutions in the context of the establishment, in Montreal, of two Integrated University Health Networks (IUHN), one linked to McGill University, and the other to the Université de Montréal.

In fact, following the Carignan report, the Health and Social Services Minister entrusted the leadership of these Montreal university networks to the Regional Board, which will be responsible for their establishment and permanence.

In order to increase synergy between the Université de Montréal and McGill University networks, the Regional Board proposes to set up a co-ordination committee for the Montreal IUHNs, with the participation of each network's main directors. Significant partnerships are already developing between the CHUM and the MUHC, particularly with regard to information systems and technology. In fact, these institutions have decided to share their technology-evaluation mandate.

The Minister has also indicated agreement with the principle of gradually implementing practice plans and career plans for physicians working in university centres.

The work of the IUHNs will lead us to specify needs in terms of the activities and resources required for academic, teaching and resource purposes.

Regional service organisation plans

The Regional Board will soon begin formulating regional service organisation plans for each medical specialty. Given the complex nature of the Montreal environment, all of the plans will be drawn up over an 18-month period starting in the spring of 2003, taking into account the Regional Medical Commission's report to this effect.

We must formulate our regional service organisation plans (PROS) in order to provide solid proof of our medical staffing needs.

The regional service organisation plans will ultimately set our objectives in terms of accessibility and volume of services, diversity of practices, hierarchisation and continuum of care.

Additionnal financial resources required

5.4 Ensuring access to medical and hospital services within recommended timeframes

	NEEDS (M$)			
	Recurring	Non-recurring	Capital expenditures	Indexation
Emergency services				
Network for rapid access to diagnostic services	17.0			
Hospital emergency rooms				
- designation of emergency rooms for CVA-patient thrombolyses				1.5
- adjustment funds to meet seasonal variations, and attendance bank		45.0		
- renovation of 10 emergency rooms			127.6	3.6
- information systems	0.2	0.5		
Start-up of two outpatient centres (Lakeshore Hospital and Maisonneuve-Rosemont Hospital)				11.0
Access to specialised medical and hospital services		65.0		75.6
TOTAL	**17.2**	**110.5**	**127.6**	**91.7**

Reaching our objective will require recurring budget developments of $17.2M, most of which will go to funding the network for rapid access to diagnostic services. It will take another $110.5M in non-recurring funds and $91.7M from budget indexation to reach the proposed objectives. An indexation rate of 2.6% would add $107M to the budget in 2003-2006 and $321M in 2005-2006, making it possible to fund this priority. This priority alone would require 0.8% indexation of the regional budget. These funds are clearly necessary to meet the growing demand for cardiac surgery, cataract surgery, hip and knee replacement, Haemodialysis and radiation oncology.

5.5 Developing integrated service programs and networks for at-risk clienteles

Setting up integrated service networks for at-risk clienteles will require joint contribution by groups of professionals who will deal with the various aspects of each individual in a comprehensive and ongoing manner. We share Lise Lamothe's view: "The challenge at the heart of this reorganisation is to rethink how the production of care is organised, so that we can integrate clinical activities in a context that does away with organisational barriers."

In fact, setting up integrated service networks in Montreal means creating functional ties (for patients' benefit) between family physicians, CLSCs, diagnostic services (laboratory, medical imaging), specialised medical and hospital services, and rehabilitation services. It is not so much a question of creating functional ties among institutions, but rather among professionals.

Targeted results

- Decrease the volume of emergency visits and hospital admissions on the part of at-risk clienteles.
- Increase the satisfaction level of the people served.
- Provide in-community support to at-risk persons

Proposed actions

- Develop integrated service programs and networks for at-risk clienteles:
  - elderly persons who are no longer self-sufficient
  - persons suffering from chronic progressive diseases:
    - chronic obstructive pulmonary disease (COPD)
    - heart failure
    - diabetes
  - persons with cancer
  - persons with HIV-AIDS
  - persons suffering from mental illness
  - persons with pervasive developmental disorders.
- Make sure that each component of the network has the resources required to play its role:
  - how can we ask family medicine groups (FMGs) to maintain constant liaison with relevant programs available in CLSCs, for their patients' benefit if FMGs do not have a nurse in charge of co-ordinating such services?
  - how can we ask CLSCs to provide programs for chronic progressive diseases to their patients and the patients of FMGs if they do not have the required multidisciplinary teams?
  - how can we deliver home palliative care without on-call medical and nursing staff to cover evenings, nights and week-ends?

Proposed actions (continued)

- Implement interactive liaison mechanisms that work.

  It is absolutely necessary to support, with effective electronic tools, the timely transmission of relevant information among components of the network:
  - referrals among professionals;
  - requisitions and results: laboratory and medical imaging.

- Build confidence among professionals in the various organisations and at different levels of service.

  In order for service networks to work, general practitioners must be sure that they can count on reasonable waiting times for consultations with specialists. Specialists must in turn feel confident about referring patients to their CLSC and family physician following hospitalisation. Finally, CLSCs must be able to rely on medical staff on call when providing palliative care.

  This condition favours a gradual approach that would foster participation and learning on the part of all those being asked to contribute: general practitioners, specialists, professionals, managers, computer experts.

- Engineer incentives to achieve the objectives of integrated networks.

  Incentives must be provided to encourage partners to do what is needed to reach integrated networks' target objectives.

  For this purpose, a non-recurring budget of $500 000 will be allocated to set up the Family Medicine Groups (FMG), with a subsequent recurring annual budget of $500 000, that will notably enable the availability of two nurses from CLSCs. Furthermore, physicians who practice in this format will receive a pay increase of approximately 8%. In the case of networks for rapid access to diagnostic services, an allocation of $17M dollars is planned to ensure increased accessibility to medical and diagnostic services.

  Finally the new understanding between the Quebec Federation of General Practitioners and the government provides for an increase in physicians' pay when they undertake the case management of an at-risk patient.

  This new protocol for case management and follow-up should provide an incentive for general practitioners to undertake the care of clienteles identified as at-risk, and to co-operate with the integrated service networks that will be developed for these clienteles.

- Establish clear contractual agreements.

  In order to ensure the longevity of integrated service networks, and as a means to properly establish respective roles, we plan to use contracts that will link partners to each other: FMG-Regional Board, FMG-CLSC, rapid access centres-Regional Board, CLSC-Hospital Centre, Regional Board-institutions.

  These contracts or agreements will formalise partners' responsibilities toward a defined clientele, and the arrangement of incentives.

- Bring about this priority in such a way as to ensure a network that is closely knit around Family Medicine Groups (FMG).

  We think that integrated service networks for at-risk clienteles can only be developed on the basis of a better-organised and better-equipped network of first-line services. Without a solid basis in terms of first-line services, It would be utopian to attempt to build integrated service networks for specific clienteles that draw exclusively on specialised services.

- Improve home care services and services in the community for elderly persons who are no longer self-sufficient.

Proposed actions (continued)

The starting point for integrated service networks for at-risk clienteles is the creation of a network that draws on the contribution of all general practitioners in Montreal who provide first-line medical services, regardless of where they practice. The challenge will then be for family physicians to identify their at-risk patients and put them into contact with the integrated service networks, developed with the CLSCs, for elderly persons who are no longer self-sufficient, persons with pulmonary disease, etc.

In the case of FMGs and CLSCs, linkages will be facilitated by the presence of CLSC nurses who will be an integral part of the Family Medicine Groups.

In order to set up integrated service networks that will foster co-operation by professionals from different organisations, we will not rely on restructuring, but rather on:

- liaison and co-ordination of services (case management) by pivotal nurses placed strategically throughout the network (FMGs, CLSCs, hospitals);
- specific programs aimed at clienteles with well-identified chronic progressive diseases (COPD, heart failure, diabetes);
- well-engineered incentives that will notably encourage participation by physicians;
- formal agreements.

5.5.1 Integrated service network for elderly persons who are no longer self-sufficient

This network of services is already quite developed in Montreal. However, given the ageing population, it needs to be strengthened considerably. It is one of the basic components of the first-line network that has priority for improvement in Montreal by 2006.

Targeted results

- An increase in the number of elderly persons receiving home care: from 37 000 to 43 000.
- More intensive services provided to each person.
- 500 social housing units with community services and other features.

Proposed actions

- Step up activities aimed at preventing health problems (influenza), social problems (abuse and negligence) and trauma (falls) that entail a loss of self-sufficiency.
- Increase Montreal's budget for home care services by $76M by the year 2006, in order to serve a larger clientele.

In its "*Making the Right Choices*" health and social services plan, the Ministry set the amount of funding required to extend home care services, increase these services and better co-ordinate services in the community at $305.4M for Quebec as a whole. Given the proportion of elderly and very elderly persons living in Montreal, this would make it possible to increase the budget for Montreal by $76M by 2006.

In 2001-2002, CLSCs provided home care to 37 185 elderly persons who were no longer self-sufficient, a number that represents 13.6% of the 273 616 elderly persons in the region. The current budget of $97.5M allows for an intensity of services corresponding to $2 622, enabling an average of 25.4 visits a year per person served. In comparison, the intensity of services provided under the SIPA project corresponded to $4 994 per patient.

Our service delivery percentage and intensity of service are above the provincial average, which is 12.5% and 20.5 visits per year respectively. This is explained by the fact that the proportion of our population over the age of 65 is considerably higher. In fact, the proportion of persons between the ages of 75 and 84 is 5.5% in Montreal, compared to 3.9% in the rest of Quebec. With regard to persons over the age of 85, our rate is 1.5 times higher than in the rest of Quebec.

Since loss of self-sufficiency increases significantly after the age of 75, and given Montreal's socio-demographic profile, needs are particularly acute in our region.

The Ministry, based on comparative studies between Quebec and other provinces of Canada, estimates the optimum percentage of persons over the age of 65 to be served by the home care program at 17 %. This percentage takes into account the fact that 41% of persons over the age of 75 have moderate or severe impairments. The current average rate of service delivery in Quebec is 12.5%, and the Ministry has set a target of 15% for 2006 and 17% for 2008.

The population over the age of 65 in Montreal will be 289 039 by 2006.

Therefore, with an additional budget of $76M, we would be able to serve, in 2006, 15% of persons over the age of 65, i.e. 43 355 persons, with an intensity of services equivalent to approximately $4 000 per person per year, or 38.6 visits a year. This will bring us up to 80% of the intensity reached in the SIPA project, which showed a positive impact on the rate of placement and on the length of emergency stays.

Proposed actions (continued)

The other option would be to reach 17% of these target clienteles by 2006. That would mean reaching 49 136 persons with a corresponding intensity of $3 531 per person.

- Ensure access to services that resemble those of the day centres in each CLSC territory.
- Ensure, in each CLSC, the setting up or consolidation of a program to provide support to informal caregivers: respite services (at home, in a day centre, in temporary placement), self-help groups and support groups, individual counselling.
- Increase alternative residential services to placement in institutions:
  - support the development of social housing units with services for elderly persons who are no longer self-sufficient;
  - ensure the services required to create 500 social and community housing units as part of the Accès-Logis (Access to Housing) program, phase 2;
  - make the required services and care available through the CLSCs for these 500 social and community housing units;
  - develop agreements with the partners concerned with regard to the complementary services required, such as safety and food;
  - develop 1 245 residential places in intermediate facilities, or in profit or non-profit private facilities.
- Implement the Multi-Clientele Evaluation Tool (MCET).

  This tool will be used to assess, at the clinical level, all requests for placement in long-term residential care facilities, and will ensure the continuity of care within service networks.

  By December 2003, 1 500 persons involved in requests for placement, and 2 000 persons concerned by the integrated service networks will receive training in how to use the Multi-clientele evaluation tool (paper format).

  Implementation of the electronic version will begin in 2004.
- Implement the electronic version of the Inter-institution Service Request.

  This electronic referral tool will be deployed in all of the institutions involved (hospitals, CLSCs, rehabilitation centres) and Family Medicine Groups (FMG).
- Introduce on-call nursing and medical services in each of the four territories covered by the CLSCs' 24-hour, 7-day-a-week switchboards.

  This on-call nursing and medical service would cover the entire city of Montreal and would be accessible to all patients registered as receiving home care from the CLSCs.

  This service targets persons:
  - who need palliative care
  - who suffer from chronic obstructive pulmonary disease (COPD)
  - who suffer from severe heart failure
  - who are no longer self-sufficient and are at high risk of developing serious physical problems.

The Ministry has set the following objectives, to be achieved within 5 years: an institutional placement rate of 3.5 beds per 100 persons over the age of 65, and an increase to 3 hours of care per day as the standard amount of care required to be eligible for admission to long-term care. This means that all regional boards must formulate a five-year action plan that emphasises support in the community, and developing various alternatives to institutional placement.

In the current context, taking into account ministerial objectives and Montreal's specific characteristics, we propose to develop, by April 2004, a regional organisation plan for residential and long-term care services by answering the following questions:

How much placement capacity should we aim for in five years, taking into account the contribution of each of the various possible formats:
- institutional placement
- intermediate resources
- family-type resources
- private for-profit placement
- private non-profit placement
- social housing with community services?

Which format would make it possible to provide the proper services to persons with cognitive impairments and who require custodial care and supervision?

How can private for-profit and non-profit placement alternatives be made available to economically disadvantaged persons?

How can we fund the development of resources that provide alternatives to institutional placement before reducing the number of places in that sector and while increasing the intensity of the services provided?

What type of resources should replace antiquated facilities?

How can we ensure 24-hour, 7-day-a-week case management of at-risk clienteles in the community?

How will the various sectors contribute to meeting the needs of elderly persons who are no longer self-sufficient: the public sector, the private sector, the co-operative sector, the social economy sector, the social housing sector, the municipal sector?

5.5.2 Integrated service network for persons with chronic progressive diseases

Treatment and follow-up services for persons with chronic progressive diseases are unevenly developed in the Montreal region. These patients frequently use medical services, hospital services and emergency services. They are also the clienteles that require the most intervention in the community. Public health data show that, among persons over the age of 65, 85% of hospitalisations are due to heart failure or chronic obstructive pulmonary disease.

Targeted results

For these clienteles:

- fewer emergency room visits
- fewer hospitalisations
- better case management
- greater satisfaction.

Proposed actions

- Strengthen multidisciplinary teams in the CLSCs to increase their capacity to manage the cases of persons with chronic progressive diseases:
  - consolidate and complete teams in the relevant disciplines: nutrition, physiotherapy, occupational therapy, speech therapy;
  - provide access to pharmacy and psychogeriatrics consultations.
- Set up a continuum of integrated services according to the model developed by the Regional Board for persons with chronic obstructive pulmonary disease (COPD) and make it accessible to persons with the following chronic diseases: heart failure, diabetes.

5.5.3 Integrated service network in oncology and palliative care

In the context of implementing the Quebec Anti-Cancer Programme (Programme québécois de lutte contre le cancer - PQLCC), the Regional Board is producing, in co-operation with all regional actors, a progress report on the organisation of oncology services. Findings include:

- overly long waiting times for access to services and technical support;
- difficulty accessing information;
- a lack of continuity among care providers, and difficulty on the part of the patient to keep track;
- an incomplete range of services, particularly with regard to psychosocial support and first-line services;
- a lack of standardisation in clinical approaches;
- the need to consolidate prevention and screening services.

To improve oncology services, it is necessary to:

- facilitate users' movement through a complex group of services;
- improve continuity from one service provider to another;
- shorten access times;

- harmonise clinical practices and approaches.

To shorten access times, we have already proposed, under priority 5.4, to add $3.9M on an annual basis to current budgets for surgical oncology and radiation oncology, as well as $6.3M in recurrent funding to improve medical imaging services.

Targeted results

More effective oncology services:

- shorter access times for services;
- ongoing services;
- high quality clinical practices and approaches;
- palliative care accessible to 5 000 persons a year in CLSCs and RLCCs.

Proposed actions

Designation of oncology centres

- Designate regional anti-cancer centres for adults and children, as well as local centres, with linkages between the two. Give these centres the mandate to implement oncology teams with the functions presented in Appendix 6 of Support Document.

  The mandate of these designated centres will be to:

- Set up the regional and local oncology teams by cancer site with their partners: hospitals, CLSCs, FMGs.
- Come to an understanding with the Regional Board for the designation of regional teams for types of cancer that are less widespread or require special expertise.

  Designation will be carried out according to the criteria of the Quebec Anti-Cancer Program (see Appendix 7 of Support Document) and according to the principles recommended by the Regional Medical Commission to make the required expertise available and provide quality services. Finally, supra-regional teams will be designated by the Ministry.

With regard to the delivery of oncology services, teams will have the following mandate:

- Observe timeframes established by experts, for everything from access to diagnostic services, to surgery, radiation therapy and chemotherapy.
- Set up interdisciplinary teams for the various tumour sites, with all of the professionals required. These teams will make it possible to link up different care providers, and will allow the patient to benefit from complete case management in a single place.
- Entrust the role of pivotal care-provider to the right professionals. The role of pivotal care-providers consists in assessing the needs of the person with cancer and his or her family and friends, but also in supporting them throughout treatment, and ensuring continuity in the activities undertaken by the various professionals involved.

Proposed actions (continued)

- Harmonise care-provider practice with more effective and efficient approaches.

Improve the range of oncology services

- Promotion and prevention
  - In the context of the Montreal Public Health Action Plan, make it a priority to wage an anti-smoking communication and intervention program;
  - Begin an information program for parents on protective measures for young children, to prevent skin cancer caused by prolonged exposure to the sun.

- Screening
  - Develop a plan to monitor, on an ongoing basis, workers' state of health and their exposure to factors of pulmonary disease linked to asbestos: asbestosis and mesothelioma;
  - Develop and apply, as part of the Montreal Public Health Action Plan, a strategy aimed at increasing women's participation in the breast-cancer screening program. The current rate is only 32.2%, whereas it should be at least 70% for the program to be effective;
  - Implement a pilot project for a cervical cancer-screening program that could be the basis for setting up a widespread program.

- Research, treatment and support
  - Set up the information systems required to:
    - facilitate access to laboratory test and medical imaging results in all five designated regional centres;
    - complete the computerisation of diagnostic research and reference centres (*centre de référence et d'investigation diagnostique - CRID*);
    - develop a regional electronic registry of tumours;
  - Shorten access times for radiation oncology and surgical oncology to meet expert-recommended standards;
  - Assign pivotal care-providers (case managers) to the designated regional centres;
  - Standardise clinical practices according to the requirements and standards developed by the Quebec Anti-Cancer Program and the Quebec Council, and train staff working in oncology accordingly;
  - Develop first-line services and standardise the service package provided by CLSCs, as part of the initiative to strengthen multidisciplinary teams for persons with chronic progressive diseases.

- Palliative care
  - Develop first-line services in palliative care in order to increase the opportunity for terminally ill persons to die at home;
  - Set up formal referral mechanisms for communication among the various partners, to ensure continuity of services between hospitals, residential and long-term care centres, CLSCs, FMGs, on-call medical and nursing services linked to the four 24/7 Info-Santé switchboards, and community organisations. Use Inter-Institution Service Requests (IISR) for this purpose.
  - Set up an integrated service network in palliative care
    - by mobilising various relevant partners,
    - by standardising clinical working tools,
    - by establishing progressive steps and referral criteria for this clientele;
  - Develop the expertise of care providers who work with those who are ill, or their family and friends, by providing basic training and second-line support from designated centres;
  - Intensify palliative care provided as part of first-line services and in residential and long-term care centres (RLCCs) to be able to serve 5 000 people a year.

5.5.4 Integrated service network for persons with HIV-AIDS and those at risk of contracting the disease

In Quebec, the vast majority of HIV-AIDS cases are found in the Montreal area. The segments of the population that are most vulnerable to this disease are often exposed to a number of risk factors (addiction, prostitution, homelessness...), coupled with mental health problems or the presence of Hepatitis C.

Targeted results

- Appropriate, accessible services for persons with HIV-AIDS and those at risk of contracting the disease.

Proposed actions

- Increase the budget by $2.5M to $12.2M in order to meet all of the needs of persons living with HIV-AIDS, and ensure adequate outreach to those at risk of contracting HIV.
- Ensure access to a range of effective preventive services that are appropriate and integrated into the living environments of each at-risk segment of the population:
  - intravenous drug users,
  - men who have sexual intercourse with other men,
  - members of cultural and indigenous communities,
  - young people on the street,
  - prostitutes.
- Ensure systematic screening of pregnant women.
- Increase medical and professional resources for first-line services and the CHUM's mobile team.
- Adapt research to deal with new issues and effective treatment and intervention methods for at-risk segments of the population.
- Set up a joint monitoring system.
- Make several types of placement available: comfort and convalescence facilities, social housing with community support, long-term residential care.
- Set up effective communication, liaison and co-ordination mechanisms among the network's various partners.

5.5.5 Integrated service network for adults with mental health problems

Set up integrated service networks on a sub-regional basis

The organisation of mental health services for adults is based on co-ordination by multi-sector or sub-regional groups. The Regional Board established these co-ordination groups several years ago. Their operational autonomy now enables them to take a leadership role in the development of integrated networks.

Sectoring no longer meet the system's needs and is an obstacle to empowering the system's users. The organisation of local integrated service networks will ensure a better distribution of services by sub-region.

The proposed solutions are aimed at ensuring the organisation of integrated services in all sub-regions, based on conclusive elements generated by ongoing experience in the field.

Targeted results

- A drop in anxiety and depression disorders.
- A drop in the suicide rate.
- First-line mental health services in all 29 CLSCs.
- Shorter stays in emergency, so as to eliminate stays beyond 48 hours, and shorten stays from 35 to 12 hours.
- Fewer hospitalisations.
- Community support for 3 000 persons and placement in family-type or intermediate resources for another 900 persons.

Proposed actions

Promotion-prevention

The Draft Montreal Public Health Action Plan proposes a number of actions geared toward prevention and promotion:

- Contribute to the awareness campaign on anxiety problems among young people between the ages of 14 and 25.
- Encourage early detection and increase the number of requests for help by using information and awareness-raising tools for the public and for care providers in the health and social services sector and in the community environment.
- Develop prevention and promotion initiatives in conjunction with the Montreal branch of the Canadian Mental Health Association, CLSCs and other partners.
- Support effective preventive clinical practices, using training and information activities and tools.

Proposed actions (continued)

- Regularly update the suicide progress report in order to support implementation of the regional prevention action plan.
- Help develop preventive activities with inter-sectoral partners.
- Support preventive clinical practices (e.g., recognition of warning signs).
- Help restrict access to means of committing suicide, and improve the case management and follow-up of suicidal persons through inter-sectoral co-ordination, begun with the task force for preventing suicide on the Jacques-Cartier bridge.

Basic services in the CLSCs

- Set up, in every CLSC, a multidisciplinary team that provides first-line mental health services.
- Ensure the provision of standardised reception, evaluation, referral and intervention services.
- Ensure the presence of at lease one care provider on each team who will be in charge of liaising with the sub-region's integrated service network.
- Develop answers to questions concerning mental health for the Info-Social service that will be incorporated into the Info-Santé service.
- Ensure follow-up for clientele referred by Info-Social and set up relay mechanisms with relevant partners: mental health counselling centres, crisis centres and Suicide-Action Montreal.

Shared medical services

- Ensure that all six sub-regions have a network that is shared by general practitioners and psychiatrists, to deliver integrated, ongoing services to persons with mental health problems.
- Ensure that each of the 11 hospital psychiatry departments provide consultation-liaison services available to general practitioners 80 hours over 7 days a week.

Integration and optimisation of specialised and ultra-specialised services

- Implement, in all 11 psychiatry departments, a new protocol for receiving requests, making it easier for persons to access services, regardless of the geographic sector for which the hospital is responsible.
- Prevent unnecessary or inappropriate visits to emergency by ensuring:
  - a schedule for emergency psychiatric consultations
  - intensive, group follow-up for frequent users of emergency
  - the presence of a liaison nurse in emergency, 80 hours a week over 7 days, in emergency rooms that offer psychiatric services.
- Finalise implementation of the Emergency Management Guide and get all hospitals to perform the actions required to cut the length of stay for psychiatric patients.
- Free up short-term hospital beds:
  - by providing access, through a regional admission system, to medium-term hospitalisation
  - by providing transitional placement for persons awaiting housing or residential care resources.

Access to residential services

- Make community support services available to 3 000 people.
- Ensure the integration of 900 persons currently placed in family-type or intermediate resources into independent housing.

Integrated forensic psychiatry services

Demand for forensic psychiatry services within the justice system has been increasing exponentially since the Criminal Code of Canada was revised in 1992. At the same time, the capacity of the Philippe Pinel Institute of Montreal, an ultra-specialised hospital with the proper expertise and environment to assess, treat and maintain custody of offenders referred by the courts, has decreased by 38 beds with the closure of two units since 1998. Furthermore, environments for receiving this clientele must meet specific safety regulations to comply with court rulings.

Targeted results

- The elimination of transit via detention centres of 500 offenders a year who need psychiatric services.
- The transfer of twenty persons toward less specialised resources thanks to community resources in forensic psychiatry.

Proposed actions

- Implement integrated services, organised hierarchically:

  First line: Alternatives to referral to the court (CLSCs, crisis centres, outpatient clinics, community organisations)

  Second line: Simple evaluations of the ability to stand trial, treatment and custody (physician at court, designated hospital centres)

  Third line: Complex evaluations of the ability to stand trial, and of criminal liability, treatment and custody of violent and dangerous criminals (Philippe Pinel Institute of Montreal).

- Recommend, as an amendment to the 1998 Minister's Order, to reduce the number of designated hospitals to four, including the Philippe Pinel Institute of Montreal).
- Create three secure forensic psychiatry units in the designated hospital centres.
- Optimise access to the Philippe Pinel Institute of Montreal by reopening the 38 beds closed since 1998.
- Transfer responsibility for medical and professional services provided in Public Security detention centres to the health and social services network.
- Develop specialised, post-residential care services to promote the transfer of clients in community residential facilities toward appropriate resources.

5.5.6. Integrated service network for persons with pervasive developmental disorders

The Regional Board has worked in co-operation with all concerned partners to develop and implement a model integrated service network for persons with pervasive developmental disorders. Pervasive developmental disorders include the following syndromes: autistic disorder, Rett Syndrome, childhood degenerative disease, Asperger Syndrome, and unspecified pervasive developmental disorder.

Targeted results

- Access to an intensive behavioural intervention program for 350 children between the ages of 0 and 5.
- An increase from 10 to 20 hours a week in services for children between the ages of 0 and 5.
- Guaranteed integrated evaluation service provided by four ultra-specialised teams.
- A drop in the average waiting time for diagnostic evaluation in any of the four designated centres (Douglas Hospital, the MUHC's Montreal Children's Hospital, Ste-Justine Hospital, Rivière-de-Prairies Hospital) from 113 to 30 days.
- A crisis support service that can reach twice the number of families a year, by doubling their number from 40 to 80.

Proposed actions

- Intensive behavioural rehabilitation:
  - Implement specialised rehabilitation services as part of intensive behavioural intervention;
  - Set up a joint regional planning initiative for all five intellectual impairment rehabilitation centres (L'Intégrale Rehabilitation Centre, West Montreal Rehabilitation Centre, the Myriam Centre, the Gabrielle-Major Intellectual Impairment Rehabilitation Centre, and the Lisette-Dupras Rehabilitation Centre);
  - Eliminate service overlaps by regulating the respective intervention areas of intellectual impairment rehabilitation centres and Hospitals with day centres.
- Diagnostic evaluation and overall needs assessment:
  - Set up specialised inter-sectoral teams for diagnostic evaluation and overall needs assessment in order to ensure integrated evaluation;
  - Specify the provision of ultra-specialised evaluation services in all four designated hospitals (Montreal Children's Hospital, Ste-Justine Hospital, Rivière-de-Prairies Hospital, Douglas Hospital), the provision of services in other Montreal hospitals, and in other regions of Quebec;
  - Develop service agreements among the four hospitals to ensure standard application of the diagnostic evaluation protocol;
  - Specify the mechanisms for co-operation and referral among the four designated hospitals and other hospitals.
- Support for families in crisis situations:
  - Adapt and consolidate support measures to help families in crisis situations.
- The organisation of services for persons with pervasive developmental disorders not accompanied by intellectual impairment:
  - Designate institutions in charge of providing services, while clarifying their role and responsibility;
  - Implement priority services in terms of intensive follow-up, rehabilitation and self-help.

Additionnal financial resources required

5.5 Developing integrated service programs and networks for at-risk clienteles

		NEEDS (M$)			
		Recurring	Non-recurring	Capital expenditures	Indexation
5.5.1	Integrated service network for elderly persons who are no longer self-sufficient				
	- increase the budget for home care services	76.0			
	- develop social housing units with community services	0.5			
	- on-call medical and nursing services	0.7			
	- implement electronic Inter-institution service requests		0.9		
5.5.2	Integrated service network for persons with chronic progressive diseases	38.0			
5.5.3	Integrated service network in oncology and palliative care	14.0	1.8		
5.5.4	Integrated service network for persons living with HIV-AIDS and those at risk of contracting the disease				
5.5.5	Integrated service network for adults with mental health problems				
	- sub-regional networks for adults	8.0	5.5	20.4	12.6
	- integrated forensic psychiatry services	1.3	3.3		6.8
5.5.6	Integrated service network for persons with pervasive developmental disorders	12.5			
Total		**153.5**	**11.5**	**20.4**	**19.4**

5.6 Setting up regional service organisation plans in four priority sectors

1. **Services for elderly persons who are no longer self-sufficient**
2. **Services for persons with physical disabilities**
3. **Services for persons with intellectual impairments**
4. **Perinatal services**

5.6.1 Regional service organisation plan for residential and long-term care

The reasons in favour of developing and adopting a regional service organisation plan for residential and long-term care for elderly persons who are no longer self-sufficient were set out in the section describing the proposed actions to improve integrated service networks for at-risk clienteles. The main element requiring clarification is the organisation of placement resources for the future, specifying the range and quality of services required, and the contribution expected from the various sectors of society to meet the constantly growing needs of the ageing Montreal population.

5.6.2 Regional service organisation plan for persons with physical disabilities

The development and adoption, by 2004, of a regional service organisation plan (in compliance with article 347 of the Act respecting health services and social services) is essential to guarantee the development of integrated service networks for persons with physical disabilities, and to ensure a common vision for integrating these persons into society.

Targeted results

- Shorter access times for rehabilitation services.
- Another 230 persons receiving services to help them remain in their homes.
- Another 1 050 persons receiving family support services.
- Another 110 places in residential and placement resources.

Proposed actions

- Develop, by April 2004, a service organisation plan for persons with physical disabilities, including:
  - the concentration of rehabilitation services for the various clienteles with physical disabilities (under the age of 75) in institutions designated according to the clientele's type of disability, age and pathology.
  - the formal establishment of integrated service networks for the following clienteles: persons who have had a CVA, persons with an amputation, children with speech and language impediments, etc.
- Entrust rehabilitation services for persons over the age of 75 with persistent motor impairments to intensive functional rehabilitation units and certain designated institutions.

Proposed actions (continued)

- Entrust rehabilitation services for persons of all ages with temporary motor impairments to designated hospitals and rehabilitation centres, and review clinical practices with regard to this clientele, more particularly for those who have undergone hip or knee arthroplasty, while targeting the provision of services on an outpatient basis and/or in a home-care context.
- Develop the in-home support and family support services provided by the CLSCs.
- Develop residential resources, including respite care.
- Develop measures to support integration.

5.6.3 Regional service organisation plan for persons with intellectual impairments

We have also proposed, as a priority, the setting up of an integrated service program and network for persons with pervasive developmental disorders, requiring an additional $12.5M per year. Other actions are required to improve access to services for persons with intellectual impairments.

Targeted results

- Another 1 120 persons receiving in-home care and support for themselves and their families.
- 354 user at the Rivière-de-Prairies Hospital integrated into resources that are adapted to their needs.
- A 50% shorter waiting list for residential social services.
- Elimination of the waiting list for socio-professional services.

Proposed actions

- Ensure access to a wide range of support services for individuals, families and the community that are based on their respective needs according to age group, near their living environment and focused on social participation:
  - with all persons receiving at least one of the support services provided in the context of an integrated continuum of services by March 2006;
  - with all families receiving a grant that meets their respite needs in the context of a CLSC program for family support.
- Develop, in co-operation with partners, a range of different residential resources that are adapted to users' needs and accessible territory-wide.
- Gradually increase job integration on the part of persons with intellectual impairments who have severe employment limitations and develop 260 places for persons awaiting socio-professional program services.

Proposed actions (continued)

Beyond additional funding, at this stage it would be relevant to have a regional organisation plan to define the contributions expected from each actor in the continuum of services, given its numerous interfaces within the health and social services network, and with other sectors of activity. The current situation leaves a number of grey areas that create obstacles to co-operation and optimum resource use.

5.6.4 Regional service organisation plan for perinatal care

The birth rate has dropped significantly in Quebec over the last few years. In Montreal, there has been a 24% decrease in the number of normal births in the last ten years. In 2000-2001, 23 828 babies were born in the nine Montreal hospitals with birthing services, compared to 31 547 in 1992-1993.

This decrease in the volume of activity in obstetric units calls the current organisation of services into question.

In the context of perinatal services, the Regional Board recognises the importance of mobilising all institutions and care providers, including physicians, to recognise their roles as important links in the continuum of services provided throughout the perinatal period, and to accept their collective responsibility to meet the needs of women and their newborns.

In this respect, there is a need to agree on the package of universal services that should be provided in the prenatal and postnatal periods, on the means of making these services available side by side, and on the ideal clinical and organisational methods of operation.

Consequently, it seems appropriate to develop an organisation plan in this area and review the contributions expected from the various sectors, as well as the associated medical staffing organisation plan. Implementing the recommendations in the frame of reference adopted in 2000 could require an additional investment of $4.1M, including $1.8M for first-line services and $2M for the development and consolidation of birthing centres and midwife services. There is also the issue of the concentration of births in this sector, since certain hospitals with birthing services have a relatively low volume of cases, and since 22.5% of births are from other regions.

Additionnal financial resources required

5.6 Setting up regional service organisation plans in four priority sectors

		NEEDS (M$)			
		Recurring	Non-recurring	Capital expenditures	Indexation
5.6.2	Regional service organisation plan for persons with physical disabilities	29.2			
5.6.3	Regional service organisation plan for persons with intellectual impairments	12.7			
5.6.4	Regional service organisation plan for perinatal care	4.1			
Total		**46.0**			

5.7 Integrating women's needs into regional planning of the various continuums of care and services

In line with the ministerial objectives and the women's health and well-being action plan, made public in January 2003 in the document "*Au féminin...à l'écoute de nos besoins*" (Listening to Women's Needs), the Regional Board wants to highlight women's needs within the priorities advanced by the various care and service continuums.

With this in mind, we continue to pursue actions already underway to raise the awareness of gender analysis amongst professionals and Regional Board management. We intend to try this approach with very relevant issues, such as the development of an integrated service network for the elderly.

Targeted results

- Regional priorities for 2003-2006 that integrate and recognise women's needs.

Proposed actions

Prevention/promotion

- Intensify promotion activities
  - social equality, particularly for young girls and boys;
  - healthy living habits (healthy diet, physical activity, body image, support to stop smoking), particularly in the school environment.
- Intensify prevention activities and interventions tailored to the needs of girls and women in order to counter:
  - violence in relationships
  - sexual assault
  - teenage pregnancy
  - suicide
  - alcoholism and addiction
  - STIs (STD, HIV-AIDS)
  - disabilities (linked to illness, social problems and trauma) affecting the elderly.

First-line services

Perinatal services

- Deploy the integrated perinatal and early childhood promotion and prevention program in all 29 CLSC territories.
- Improve access to different birthing places for women who use the services of midwives.
- Assess and readjust the services provided by CLSCs following early discharge home after delivery.

Birth planning

- Improve access to and the availability of support services to deal with unwanted pregnancy.
- Ensure follow-up and evaluation of measures to consolidate services for voluntary interruption of pregnancy.

Conjugal violence and sexual assault

- Strengthen the continuum of services to deal with conjugal violence:
  - intensify screening and referral services for persons dealing with conjugal violence, paying particular attention to those who are most at-risk: children exposed to conjugal violence, young parents, elderly persons who are no longer self-sufficient;
  - intensify rapid intervention in crisis situations (24-48 hours following the assault) for victims and attackers;
  - consolidate and develop basic services for women victims of conjugal violence, exposed children and attackers.

Proposed actions (continued)

- Strengthen the continuum of services to deal with sexual assault:
  - consolidate and develop activities linked to screening and appropriate referral for sexual assault victims;
  - improve intervention in crisis situations;
  - consolidate the basic services available to victims and attackers.

Physical health

- Continue implementation and follow-up of the Quebec Breast Cancer Screening Program.

Mental health

- Support the development of gender-analysis skills on the part of personnel in the field of mental health.

Ageing and loss of self-sufficiency

- Re-evaluate the needs of family caregivers who take care of persons who are no longer self-sufficient.
- Gradually increase the services available to family caregivers, taking into account an approach based on gender analysis.

Specialised or rehabilitation services

- Ensure that services are adjusted to take into account the situation of women facing multiple problems, while remaining focused on allowing them to remain in their home living environment.
- Set up follow-up teams for persons with chronic diseases, particularly for women with cardiovascular disease.
- Adjust the home care provided by CLSCs to women with physical or intellectual disabilities. These services must take into account aspects such as: birth control, various forms of violence, perinatal services, etc.
- Adjust alcohol and addiction interventions to take women's needs into account, particularly those of young women and women in prison who use drugs, and those of older women with problems linked to over-consumption of medication.

Access times

- Observe maximum access times for specialised medical and hospital services for:
  - breast cancer
  - cervical cancer.

Consultation will enable us to check whether these proposals will help adjust our services to meet the specific needs of women, and align our priorities in this direction.

5.8 Respecting the linguistic and cultural characteristics of the population

Respect for ethnocultural and linguistic diversity is one of the fundamental guidelines of the Regional Board, which must keep a delicate balance between the various expectations of the population and the rights at stake in the context of available resources and the laws and policies in effect.

First of all, the Charter of the French Language makes it clear that everyone has the right to receive services in French in all institutions. Furthermore, the Charter confers the right to work in French. However, it allows employers to request knowledge of a language other than French if the position so requires.

Furthermore, all English-speaking persons have the right to receive health and social services in English, taking into account available resources and insofar as they are provided for in an access program. This Access program is the Regional Board's tool to ensure that this right is respected.

We have striven to maintain this delicate balance through the Program for access to English-language services, which has been in effect in the region since 1989. It was revised by the Regional Board in 1996, and the new program was approved by the government in 1999.

There have been very few complaints from users and employees since this program was introduced.

Plan for access to services in English (designated and suggested institutions) and for cultural communities

	CH	CLSC	CPEJ	CHSLD	CR	Total
Designated	13	0	1	13	10	37
Suggested	7	26	0	7	5	45
Institutions with programs for access by cultural communities	6	9	2	2	2	21

In order to facilitate access to services, and support the work of care providers in the health and social services network, the Regional Board set up a bank of interpreters and translators who offer services in 67 languages. In 2001-2002, this team received over 10 000 requests, and provided 19 000 hours of interpretation.

We must develop our regional service organisation plans, making sure that they fully take into account the socio-cultural and linguistic characteristics of the population and of the institutions designated or suggested to provide services in French and in another language, mainly English.

5.9 Summary of additional resources required

Achieving the targeted results for all six priorities will require additional recurring funds of $355.2M a year, starting in 2005-2006.

Additionnal financial resources required

To achieve the six major priorities for Montreal in 2003-2006

		NEEDS (M$)			
		Recurring	Non-recurring	Capital expenditures	Indexation
5.1	Reducing the impact of social inequality on health through effective prevention	42.0			
5.2	Acting in partnership to provide appropriate solutions to Montreal's social problems	31.7			
5.3	Developing a network of first-line services that are closely knit around the Family Medicine Groups (FMG)	64.8		29.0	
5.4	Ensuring access to medical and hospital services within recommended timeframes	17.2	110.5	127.6	91.7
5.5	Developing integrated service programs and networks for at-risk clienteles	153.5	11.5	20.4	19.4
5.6	Formulating regional service organisation plans in four priority sectors	46.0			
TOTAL		**355.2**	**122.0**	**177.0**	**111.1**

The proposed measures represent non-recurring costs of $122.0M, capital expenditures of $177M and an annual attribution, in 2005-2006, of $111.1M for the indexation of health and social service costs. The indexation rate needed to cover the rise in health-specific costs was estimated at 2.6% in the Ministerial Action Plan *"Making the Right Choices"*. In Montreal, this rate would correspond to an additional amount of $321M per year starting in 2005-2006.

These additional budget amounts are needed to:

- reduce the impact of social inequalities on health;
- encourage the development of children and young people with adjustment problems;
- prevent chronic diseases;
- provide rapid, first-line treatment for physical and mental problems, and common social problems;
- provide access, within clinically recommended timeframes, to specialised medical and hospital services;
- provide the support and treatment required to at-risk clienteles:
  - elderly persons who are no longer self-sufficient;
  - persons with chronic progressive diseases (chronic obstructive pulmonary disease, heart failure, diabetes);
  - persons with cancer;
  - persons with HIV-AIDS;
  - persons with mental health problems;
  - persons with pervasive developmental disorders.

To reach these objectives, we will focus on considerably strengthening prevention and basic first-line services:

- increase our prevention efforts twofold;
- implement 58 Family Medicine Groups (FMG) that will liaise with 29 CLSCs offering health and social services accessible 7 days a week, for a total of 80 hours;
- create a network for rapid access to diagnostic services by designating 30 points of service that will be open from 8:00 am to 8:00 pm, 7 days a week;
- increase by 1.8 times the volume of home care services available to elderly persons who are no longer self-sufficient;
- create integrated service networks for at-risk clienteles, ensuring that the required services are available in the community, and reversing the trend of resorting to emergency services and hospitalisation.

Reaching the priority objectives proposed for 2003-2006 will require:

- building a strong consensus in their favour in Montreal;
- ensuring the necessary leadership and co-ordination so that integrated service networks and inter-sectoral interventions will work properly in the field;
- meeting management challenges linked to:
  - the availability and mobility of physicians and human resources;
  - the availability of information resources required by physicians and personnel to network, and by managers to make decisions based on conclusive data;
  - the strategy for funding priorities.

6. A territorial approach to intersectoral coordination and service integration

6.1 THE MONTREAL PUBLIC HEALTH ACTION PLAN AND THE REGION'S MUNICIPAL, SCHOOL AND HEALTH & SOCIAL SERVICES DISTRICTS

The purpose of the proposed Montreal Public Health Action Plan is to improve the health and well-being of Montrealers. Although the plan is a regional one, it will necessarily rest on local action plans defined at the level of the territories of the various CLSCs.

At the regional level, the situation is much simpler than it used to be, because we only have to work with the new City of Montreal as opposed to 29 separate municipalities. However, at the local level, the situation remains very complex because the territorial boundaries of the City, the Regional Board and the school boards do not at all coincide.

> ***"... Changing the way the service territories are defined would make cooperation between the partners easier. At the present time, the municipalities have their territories, the school boards have theirs and the HCs have others still, making partnership difficult and ultimately promoting disengagement. It would be easier to get the people who are in a position to influence their organisations on the joint action and consultation committees to participate if the territories coincided. That way, we would probably have fewer committees, and they would be efficient and effective."***[1]

Many of the objectives proposed in the draft Montreal Public Health Action Plan raise the issue of the local territory of reference, because they cannot be achieved without the contribution of all partners, especially the City of Montreal and school boards.

Non-coincident boundaries for the local municipal, school board and health & social services districts

When we compare the 27 boroughs of the City of Montreal and the 29 CLSC territories, only three of them - Montreal-North, St-Léonard and LaSalle - coincide exactly.

As for the five school boards, there are five overlapping territories, with three huge francophone sub-regions and two on the anglophone side.

1 *Réflexion partagée de la réalité montréalaise en matière de santé et de services sociaux,* Regional Multidisciplinary Commission of the Montreal-Centre Regional Board, November 2002

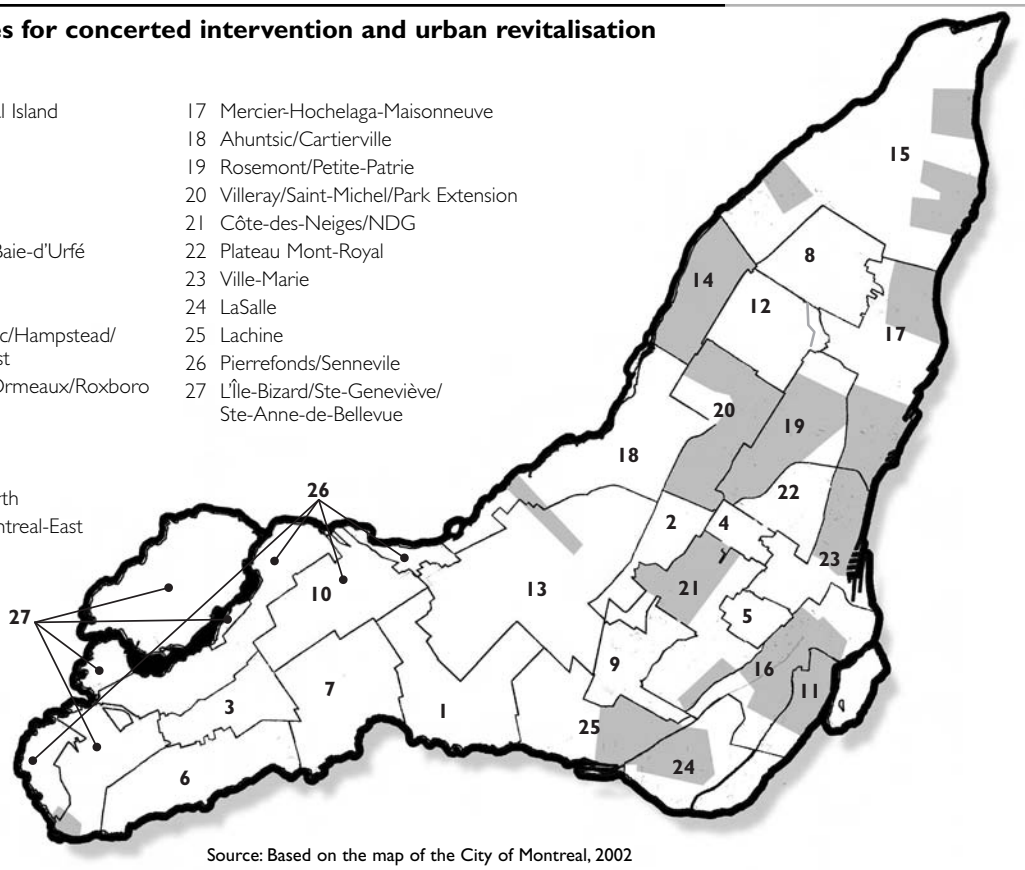
New tools for intersectoral coordination

Despite this complexity, there are a number of factors that favour better coordination and integration of the efforts of the municipal, school and health & social services partners to fulfil our shared responsibility to improve the health and well-being of Montrealers.

Priority zones for concerted intervention and urban revitalisation

Borough No.

1 Dorval/Dorval Island
2 Mount-Royal
3 Kirkland
4 Outremont
5 Westmount
6 Beaconsfield/Baie-d'Urfé
7 Pointe-Claire
8 Anjou
9 Côte-Saint-Luc/Hampstead/ Montreal-West
10 Dollard-des-Ormeaux/Roxboro
11 Verdun
12 Saint-Léonard
13 Saint-Laurent
14 Montreal-North
15 RDP/PAT/Montreal-East
16 South-West
17 Mercier-Hochelaga-Maisonneuve
18 Ahuntsic/Cartierville
19 Rosemont/Petite-Patrie
20 Villeray/Saint-Michel/Park Extension
21 Côte-des-Neiges/NDG
22 Plateau Mont-Royal
23 Ville-Marie
24 LaSalle
25 Lachine
26 Pierrefonds/Sennevile
27 L'Île-Bizard/Ste-Geneviève/ Ste-Anne-de-Bellevue



Source: Based on the map of the City of Montreal, 2002

PROPOSED SOLUTIONS

Acquire better tools for intersectoral coordination by:
- using the City Contract between Montreal and the Quebec Government;
- establishing common priority zones for concerted intervention between the City, the Ministries, the Regional Board and the school boards;
- generalising and harmonising effective prevention programs that are accessible in all of the CLSC territories;
- synchronising and harmonising the regional strategic plans of the main partners (the City, the school boards and the Regional Board); and
- sharing and disseminating information between the respective territories of the boroughs, CLSCs and school boards.

6.2 HEALTH AND SOCIAL SERVICES INTEGRATION AND COORDINATION AND TERRITORIAL DIVISIONS

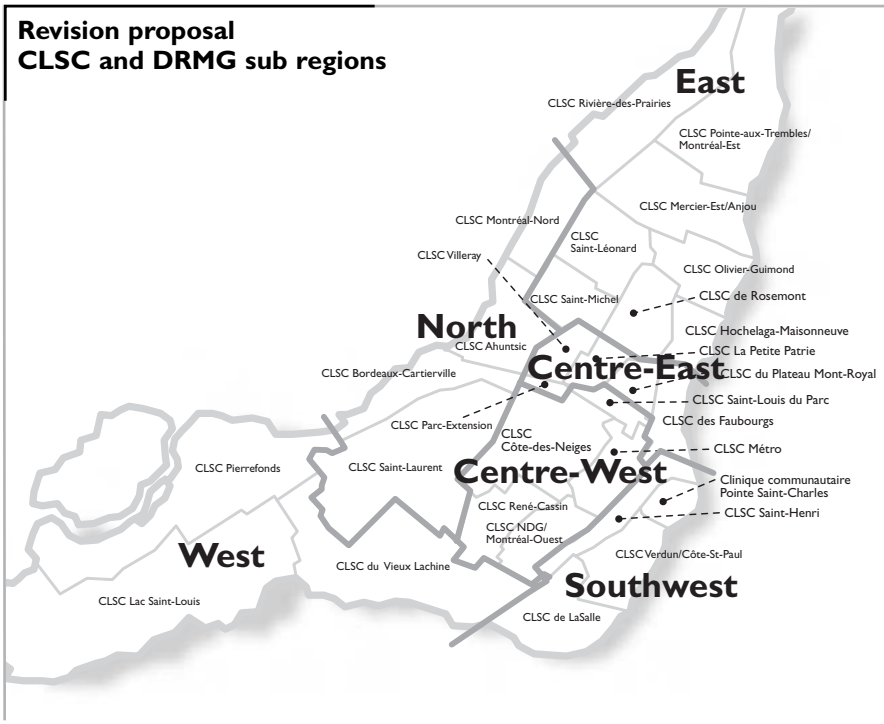
Within Montreal health and social services network, people are asking themselves what contribution the territorial approach to the integration and coordination of services can make, particularly in the following service continua: front-line care, services to elderly people who are no longer fully self-sufficient, physical health and mental health. The same question is being raised with respect to youth services, an area where cooperation between the CLSCs, the Youth Centres and the school boards is essential.

Here again, the situation is complex in Montreal because there are so many different players responding to particular needs of the population that will have to coordinate their efforts if we want to provide access to integrated and continuous services.

PROPOSED SOLUTIONS

- Harmonisation and simplification on the basis of the CLSC territories and the sub-regions proposed by the Regional Department of General Medicine.
- Liaison and standardisation
  - common clinical protocols
  - electronic communication tools
  - rapid access to diagnostic services.

Revision proposal
CLSC and DRMG sub regions



7.
Management challenges 2003-2006

The achievement of the proposed health and well-being improvement objectives for Montrealers depends on how successfully we meet six major regional network management challenges, namely:

1. **Implementing new management tools designed to achieve results as measured against pre-defined objectives, transparency and accountability, through:**
   - management agreements with the institutions; and
   - a balanced assessment of results and performance.
2. **Ensuring the availability and motivation of physicians.**
3. **Ensuring the availability and motivation of human resources.**
4. **Providing access to the information systems and technologies health professionals needs to network, and managers need to manage on the basis of accurate, up-to-date data.**
5. **Maintaining and strengthening the strategic partnerships within the Montreal community.**
6. **Developing a funding strategy to optimally manage resources and deliver on the health and well-being improvement priorities for 2003-2006.**

7.1 Implementing new management tools designed to produce results as measured against pre-defined objectives, transparency and accountability

Devoting additional resources to the Montreal health and social services network will only be useful to the extent that we optimally manage all of our human, financial, material and informational resources.

Before looking at coming developments, which could represent a recurring increase of about 3% a year between now and 2006, we need to look at the present 100% of Montreal's 2002-2003 budget of $4,133B for the provision of services by 82,500 employees and subsidies of $50.5M to over 500 community organisations. We also have real estate assets with an estimated replacement value of $4 billion and information system equipment worth almost $200M.

To this, we must add the contribution of 3,216 specialists and 2,190 general practitioners, who were paid a total of $722,915,691 in 2000-2001.

Our current financial resources are devoted primarily to funding physical health services (48.5%), services for elderly people who are no longer fully self-sufficient (25.5%) and mental health services (11%). Together, these three programs take up 85% of our financial resources. The allocation of resources between the programs has remained relatively stable since 1994-1995.

In order to recognise and optimise all of the work done by the institutions that are responsible for the delivery of health and social services perceived as efficient, effective, appropriate and satisfactory by their beneficiaries, we are relying first and foremost on two structuring and motivating tools.

7.1.1 Management agreements with the institutions

Historically, the evolution of service provision in Quebec has depended on available resources and the efforts made by the various institutions to ensure their development. As the Clair Commission so clearly demonstrated, this approach is in urgent need of revision if we want to more fully integrate services and improve the system's efficiency.

Recent legislative changes require each Regional Board to sign an agreement with the Ministry. The specific content of these agreements remains to be worked out, but we already know that they will include province-wide health and well-being objectives, certain standards of quality, activity levels the region will be expected to reach and the resources allotted to achieve the targeted results. In order to arrive at agreements with the Boards, it goes without saying that the Ministry has to produce a province-wide strategic plan that takes into consideration the state of health of the population, the resulting needs and the government's budgets for health and social services.

In order to follow through on its agreement with the Ministry, the Board must in turn sign a management agreement with each of the institutions within its jurisdiction. These agreements must be drafted in cooperation with the institutions to ensure that they are transparent and equitable. They must clearly state the mandate and responsibilities of the institutions in addition to specifying the targeted results and the indicators and means that will be used to evaluate the results. As managers in the institutions and at the Board, our challenge is to produce these agreements. We need to take this opportunity to improve practices and remind ourselves that our system can only reach its maximum efficiency if it is flexible, equitable and accessible.

Four-part agreements

To reflect the spirit of the law and the requirements stated by the Minister, the management agreements will consist

of four parts. The first will define the volumes of services to be provided. The second will specify the resources the institution will be given to provide these services. The third part will indicate the institution's expected contribution to the achievement of the province-wide and regional objectives derived from the strategic plans of the Ministry and the Board. The fourth part will specify the indicators and evaluation processes that will be used during and at the end of the management agreement. The agreements are to be renegotiated every year, but they will clearly be part of a three-year plan.

7.1.2 Evaluating for improvement

Evaluation as a means of ensuring continuous improvement in the health and well-being of the population and the performance of the health and social services network has been a priority of the Montreal Regional Board since 1994. We feel that we now have the conditions that would enable all of Montreal's institutions to implement a continuous user satisfaction improvement program adapted to the specificities of the region, and to include user satisfaction objectives in their management agreements.

Targeted results

- Continuous and observable improvement in the usefulness, effectiveness, efficiency and appropriateness of services.
- Information to the population on the results.

Proposed actions

- Create an information tool to evaluate the achievement of the objectives of the regional plans and monitor the management agreements with the institutions.
- Implement this information tool on the basis of currently available data in order to monitor the objectives in the regional plans and management agreements.
- Develop and validate, with the various parties in the network, indicators that are or should be included in the performance evaluation model for the regional network and that for the institutions.
- Gradually incorporate new network and institution performance indicators into the information tool.
- Analyse performance-related factors to generate proposals of means to improve services.
- Evaluate the results according to various geographic and socio-demographic variables.
- Make the results of the performance evaluation available to the partners and the population.
- Continuously improve performance measurement.

Targeted results

- Continuous user satisfaction improvement programs in all of the institutions.
- 60% of the patients very satisfied in all of the evaluated institutions and services.
- Improvement on the scores obtained in the 2002 and 2003 Bills of Health (hospitals and CLSCs).

Proposed actions

- Include improvement objectives in the user satisfaction section of the management agreements to be signed with the institutions. This should start in 2003-2004, with improvement objectives being tied to the Bill of Health scores of the institutions concerned (hospitals, CLSCs).
- Provide the institutions with all of the developed instruments, including the IS support (SEQUS, SIGP) needed to manage the improvement programs locally and regionally, thereby enabling continuous evaluation.
- Periodically evaluate the population's expectations regarding health and social services and their relative importance.
- Support the People's Forum in the development of its recommendations on means to improve the population's satisfaction.
- Support the local managers and service quality commissioners in the management of the continuous quality improvement programs.
- Cooperate with the accreditation agencies (Canadian Council, *Conseil québécois*) to consistently develop and standardise the evaluation tools used to accredit institutions, arrive at performance scores and monitor management agreements.
- Enforce the Safe Provision of Health and Social Services Act (Bill 113) by seeing to it that all institutions:
  - set up a risk and quality management committee; and
  - develop a disclosure policy on all accidents or incidents:
  - keep a local register for the reporting of all accidents or incidents.
- Implement a system to evaluate the appropriateness of hospitalisations and stays in all the general and specialised care hospitals.

Additionnal financial resources required

7.1 Implementing new management tools designed to produce results as measured against predefined objectives, transparency and accountability:

- management agreements in the institutions
- a balanced assessment of results and performance

	NEEDS (M$)			
	Recurring	**Non-recurring**	**Capital expenditures**	**Indexation**
Support for the implementation of a system to evaluate the appropriateness of hospitalisations and stays		4.8		
Generalisation of the continuous user satisfaction improvement program		1.5		
TOTAL		**6.3**		

7. 2 Ensuring the availability and motivation of physicians

Following through on the priorities of the 2003-2006 Montreal Improvement Plan for Health and Well-being implies second management challenge - deploying effective strategies to ensure the availability and motivation of physicians.

To meet this challenge, we must:

- promote participation;
- make sure that decisions are made quickly; and
- maintain lines of communication with the physicians.

It is with this in mind that the two medical services organisation plan proposals that are an integral part of the consultations leading up to the adoption of our 2003-2006 strategic plan were developed by Montreal physicians.

The physicians are being consulted directly on the two proposals, as well as on the strategic plan and the Montreal Public Health Action Plan. The fact that the consultation processes are synchronised means that the decision-making process will be more coherent and transparent.

7.2.1 General practitioners

Organisation plan

In the draft General Medical Services Organisation Plan, the Regional Department of General Medicine proposes the goal of improving the organisation of first-line medical services.

Targeted results

- Access 365-days-a-year to comprehensive services that ensure patient care and follow-up.
- Ongoing care for vulnerable clienteles.

Proposed actions

- Establish a network of integrated first-line medical services, accessible 365-days-a-year, that ensures comprehensive services, care and continuity for the whole population to be served, and supports the pooling of existing medical resources.
- Ensure care for vulnerable clienteles who are no longer fully self-sufficient due to age or chronic or terminal illness, in each of the sub-regions, in a perspective of complementarity with the network.
- Organise first-line medical services for clienteles with mental health problems, using a model of shared cared between general practitioners and specialised psychiatric teams, for a integrated network of continuous psychiatric care in each of sub-regions of the Regional General Medicine Department.

Proposed actions (continued)

- Integrate preventive clinical practices into routine medical practice.

  The Department's general medical services organisation plan proposal reiterates the need for timely first-line access to diagnostic services and specialised medical services.

  These proposals are consistent with the proposed actions in the Montreal Priorities - 2003-2006 section of Chapter 5, particularly with respect to:
  - family medicine groups (FMGs);
  - rapid access to diagnostic services;
  - integrated networks for the vulnerable clienteles; and
  - prevention.

The consultations with physicians and the community as a whole will improve the proposals and enable the Regional Department of General Medicine to submit a revised general medical services organisation plan for adoption.

Staffing plan

The data from the Quebec Federation of General Practitioners (*Fédération des médecins omnipraticiens du Québec - FMOQ*) analysed in the proposed Montreal Organisation Plan for General Medical Services clearly show that, between 1992 and 2001, the practice of medicine has shifted toward institutions such as the CLSCs and the RLCCs, to the detriment of doctors' offices and clinics (-107.7 FTE). In view of the fact that doctors' offices and clinics are the main point of access to medical services, the Regional General Medicine Department is concerned by this trend.

Targeted results

- A medical staffing plan consistent with the 2003-2006 priorities and the maintenance of second-line services.

Proposed actions

- Develop the regional general medical staffing plan in accordance with the Ministry's orientations and the region's needs, and make the management procedures known to those concerned.
- Update and assess the general practice needs in all of the region's institutions to identify the priority institutions and sectors where there are real and immediate medical staffing needs, in the following order:
  1. general and specialised hospital centres
  2. CLSCs and doctors' offices
  3. residential and long-term care centres and psychiatric hospital centres
  4. general and specialised hospital centres with a rehabilitation mandate, rehabilitation centres, etc.
- Establish criteria for allocation and medical staffing adapted to the region's reality, in order to safeguard acquired assets and ensure a second line, without service interruption.
- Identify and list particular medical activities and prioritised sectors in order to maintain second-line general practice, without weakening the first line.
- Reorganise the first line and evaluate the staffing requirements in order to ensure the accessibility, management and continuity of medical services suited to the needs of the population.
- Adjust the regional medical staffing plan according to the organisation plans and medical staff of the institutions and Regional General Medicine Department's Montreal Organisation Plan for General Medical Services.

7.2.2 Medical specialists

Organisation plan

The Regional Medical Commission, whose role is to advise the Regional Board's Board of Directors, has prepared a submission in which it proposes a basis for the development of the regional specialised medical services organisation plan and the staffing plans in the 34 specialties in question.

PART I: "The general practitioner-specialist interface in a network of accessible services":

Hierarchisation of medical services and definition of fields of practice

Recommendations of the Regional Medical Commission (RMC)

- That the Board of Directors of the Montreal-Centre Regional Board adopt the concept of hierarchisation of the medical services under consideration.
- That the president and executive director of the Regional Board:
  - inform all of the Regional Board's departments that he wants to see general and specialised medical services within the jurisdiction of the Montreal-Centre Regional Board organised in a manner consistent with this concept;
  - inform all of the management teams, the professional services departments, and the councils of physicians, dentists and pharmacists in the institutions and all of the physicians within the Board's jurisdiction that he wants to see general and specialised medical services of the Montreal-Centre Regional Board organised in a manner consistent with this concept;
  - make concerted representations to the faculties of medicine and Collège des médecins du Québec to ensure that the training they provide prepares their graduates to adequately perform the duties of first-line, second-line and third-line physicians;
  - make representations to the medical federations and the Ministry to get them to adopt this concept and to adopt concrete measures to promote the hierarchisation of medical services (e.g., remuneration method and adjustment of the regional medical staffing plans, budgets and communications network, etc.);
  - educate the population on the need to see a general practitioner before seeking specialised services.
- That the Medical Affairs Department and the Regional Department of General Medicine cooperate closely in organising services in accordance with the hierarchisation concept.

Access to technical/diagnostic facilities

In order to make the level of access required for the proper management of patients' health problems available, the Regional Medical Commission recommends:

Recommendations of the Regional Medical Commission (RMC)

- That the Regional Board develop, in cooperation with the institutions and free-standing clinics, an action plan to provide access to technical/diagnostic facilities that meets the needs of a well organised first-line network throughout the Board's jurisdiction, on an extended 7-days-a-week schedule that takes clinical situations recognised as urgent, semi-urgent and elective into consideration.
- That service agreements be signed between the Regional Board and the free-standing clinics to ensure access to technical/diagnostic facilities, at no additional charge, for all patients.
- That the Regional Board identify and make known to all physicians the list of locations where these services can be made available within the established timeframes.
- That a joint follow-up committee (Medical Affairs Department - Regional Medical Commission - Regional Department of General Medicine) advise the Regional Board on the orientations to be prioritised, given the identified constraints, to equip the first-line network with the tools it needs to play its role in the various clinical situations throughout the territory.

Recommendations of the Regional Medical Commission (RMC)

- That the computerisation of the network and the deployment of modern communication technologies be used to support and enable the organisation of first-line medical services.
- That the Montreal-Centre Regional Board's Medical Affairs Department seek the cooperation of Collège des médecins du Québec and the various entities involved in medical training (universities, professional associations and federations) in efforts to optimise the appropriate use of the technical/diagnostic facilities (pre-doctoral training objectives, continuing medical education, design, updating and distribution of user guides).
- That the Regional Board, in cooperation with the institutions and the clinics affiliated by service agreement, promote the implementation of an evaluation mechanism that will allow for an effective response if waiting times for access to technical/diagnostic facilities become unacceptable.
- That the Regional Board, report annually to the Regional Medical Commission on the status of these recommendations.

Access to the consultation in specialty

Recommendations of the Regional Medical Commission (RMC)

- That the Montreal-Centre Regional Board make a priority of computerising the offices of referring and consulting physicians and providing them with the necessary links to the Health and Social Services Telecommunications System (RTSS).
- That the Montreal-Centre Regional Board immediately request and provide support for efforts by the institutions within its jurisdiction to optimise the use of modern communication technologies (fax, secure e-mail) and the clerical support the specialists need to communicate the relevant information to the referring physicians.
- That the Regional Board's Medical Affairs Department seek the involvement of the Collège des médecins du Québec in efforts to improve the quality of the information exchanged by consulting specialists and referring physicians (precisely worded requests for consultation accompanied by all of the relevant information, consultation reports that provide as much information as possible on the investigation, treatment and follow-up plans, follow-up reports with subsequent test results).
- That the Montreal-Centre Regional Board, in cooperation with the institutions, encourage the use of a standardised summary medical information form when a patient is discharged from hospital.
- That the Regional Board identify and make known to all physicians the locations where these specialised consultation services can be made available within the established waiting times, and make sure that the information is updated periodically.
- That the Regional Board ask the medical specialists' associations and the professional services departments of the generalised and specialised hospital centres within its jurisdiction to help choose the means to remove the obstacles to achieving the accessibility objectives in the various sub-regions.
- That the Regional Board, in cooperation with the institutions, favour the implementation of an evaluation mechanism that makes it possible to respond effectively if the waiting times for consultations in specialised external clinics become unacceptable.
- That the Regional Board report yearly to the Regional Medical Commission on the status of these recommendations.

PART II: "Guidelines for development - Networking: a model for more accessible services":

Cooperation and complementarity between institutions, with relative autonomy in each of the sub-regions

Recommendations of the Regional Medical Commission (RMC)

- That the Professional Services Directors Committee, using such information as the Medical and University Affairs Department's recent study of actual and anticipated shortages of specialised medical staff, identify to the Regional Board the institutions, departments and specialised clinical services whose situations reflect one or more of the problems mentioned in the premises and which would be interested in participating, on a voluntary basis, in the development of an inter-institution cooperation and complementarity project. Should two institutions be experiencing staff shortages in the same discipline, the Medical and University Affairs Department will determine which of the two will get additional medical staff under an agreement between the institutions.
- That the Regional Board and the institutions concerned work together to identify and establish winning conditions for each of the participating institutions, such as:
  - the organisation of the targeted medical services, including the on-call system;
  - the human and material resources required for effective and efficient use of specialised medical staff, as provided for in agreements; and
  - the necessary budgets, with consideration for such things as:
    - the increase in costs where the services are rendered; and
    - the increase in the amount of services rendered.
- That the Medical and University Affairs Department, in cooperation with the Regional Medical Commission, manage medical resources in such a way as to promote the complementarity of services and the sharing of resources, using such means as the exemption mechanism, when appropriate.
- That the Medical and University Affairs Department secure the Ministry's authorisation to manage medical staffing on a regional basis, in the event of regional shortage of medical staff in a given specialty.
- That the Professional Services Directors Committee, the Medical and University Affairs Department and the Specialised, Ultraspecialised and Physical Health Rehabilitation Department identify the services in the university institutions that could be provided in non-university institutions, in a framework of complementarity and cooperation between them. This type of cooperation can also be developed between non-university and university hospitals.

  In this context, the institution whose service coverage is ensured by the staff of another institution should allow that institution to use its human and material resources for the services that would be transferred there (e.g., use of operating rooms for surgery).
- That the Regional Board and the Ministry agree to a model contract[2] that they would implement and distribute. The contract would spell out how the institutions would share specialised medical staff and service corridors given their respective missions.

2 | *Collaborations complémentaires entre établissements : partage des effectifs,* PROSEM Committee, RMC, May 2003, Appendix 2

The maintenance of a critical mass of patients and medical staffing essential to the provision of quality services and the maintenance of professional competence.

Recommendations of the Regional Medical Commission (RMC)

- The Regional Medical Commission recommends that the Standing Consultative Committee on Medical Staff Planning in Quebec (*Table de concertation permanente sur la planification des effectifs médicaux au Québec*) consider these aspects and take them into consideration in its next planning exercise.
- The Commission also recommends that the Regional Board and the institutions agree to concentrate certain types of surgical activities and to facilitate access to their operating rooms.

  The Commission also suggested principles to be applied to the process of concentrating specialised medical services and designating hospital centres. The Commission's recommendations on these questions were already presented in Chapter 5, as part of priority 5.4 "Ensuring access to medical and hospital services within the recommended timeframes".

Affiliated medical clinics

Recommendation of the Regional Medical Commission (RMC)

- That the president and executive director of the Regional Board approach the Ministry and propose that affiliated medical clinics be established, in cooperation with the Fédération des médecins spécialistes.

Staffing plan

The Commission proposed a series of recommendations on:

- the methodology to be used to define specialised medical staffing needs;
- the basic specialties that must be present in all the hospital centres with operating rooms

Basic specialities	
Anatomical pathology	Psychiatry
Anaesthesiology	Orthopaedic surgery
General surgery	Gynaecology
Internal medicine	Diagnostic radiology

- the other medical and surgical specialties and laboratory specialties;
- the concentration of services and ultraspecialised medical staff; and
- the organisation of specialised medical services on a sub-regional basis.

At the request of the Commission, these recommendations, which are detailed in its report,[3] have been submitted for consultation to the main stakeholders, and more particularly to the Councils of Physicians, Dentists and Pharmacists, the directors of Professional Services, the Collège des médecins, the physicians' professional associations and the two faculties of medicine.

This report will obviously be one of major contributions to be considered, along with the new agreement that has just be signed with the Quebec Federation of Medical Specialists (Fédération des médecins spécialistes du Québec - FMSQ), in drafting the regional service organisation plans and specialty staffing plans that we will be adopting in the coming months and years.

3 *"Action for Access"*, Montreal Organisation Plan for Specialised Medical Services and Medical Staffing, Regional Medical Commission, December 2002

7.3 Ensuring the availability and motivation of human resources

Delivering on the priorities outlined in Chapter 5 will require a significant injection of resources. In absolute terms, more than 4,000 additional people would be required. However, given the current and anticipated shortages, we are forced to conclude that the solutions to the network's problems cannot be implemented using the traditional approaches.

We have no choice but to ask a number of questions:

Will the amendments to Bill 90 and the work organisation exercises enable us to reallocate certain resources?

How can technology help us increase efficiency?

What are the truly unavoidable developments?

What contribution could the community organisations, the social economy sector, private practice professionals and private companies make?

Could natural caregivers provide certain services in exchange for a direct allowance?

We will have to be imaginative in our use of resources if we realistically want to our projects to succeed.

7.3.1 Adopting an integrated human resources plan

Targeted results

- A local human resources plan submitted by each institution (present staff complements and projected needs).
- A regional action plan for each sector of employment where there are shortages.

Proposed actions

- Develop integrated human resource planning between the institutions and the Regional Board to ensure a more rapid response to projected needs, both quantitative and qualitative.
- Provide each institution with a tool and the required support to plan its needs and the evolution of its staff numbers within the regional services plan.
- Work with the institutions to develop a specific action plan for each sector of employment where there are shortages, such as nursing, psychosocial services, rehabilitation, administrative services and services related to material resources.
- Carry out joint, targeted regional actions to retain staff, overcome shortages, reduce the local costs of shortages, and avoid duplication of initiatives.
- Adopt a simple and effective integrated (Regional Board - institutions) information system in order to more accurately estimate needs and allocate additions to staff according to the established priorities (short-, medium- and long-term).

7.3.2 Rethinking the organisation of work

Targeted results

- A structured work reorganisation project in each institution.
- A regional training and awareness-building program to support the reorganisation of work.

Proposed actions

- Adapt the work reorganisation program in nursing to all of the sectors of activity within the jurisdiction of the health and social services network.
- Encourage each institution to implement its own work reorganisation program.
- Provide managers and affected employees with appropriate training programs to prepare for changes in work organisation processes and models and the enactment of the Act amending the Professional Code and other legislative provisions in the field of health (Bill 90).

7.3.3 Ensuring management succession

Targeted results

- Training for 1,245 people to ensure management succession by 2006.

Proposed actions

- Implement a senior management succession program.
- Adjust the content of development programs for senior and middle managers according to need.
- Identify successors to senior and middle managers for the next three years.
- Review the staffing and recruitment policies for senior and middle managers.
- Support the development of candidates with appropriate funding.
- Identify and propose changes in working conditions and conditions of practice in order to retain and attract higher-level managers.
- Identify and propose organisational approaches to bridge the gaps in executive staffing.

Targeted results

- Availability of a regional pool of candidates who have been evaluated, qualified and trained to perform managerial duties.

Proposed actions

- Create a regional pool of candidates who have been evaluated, qualified and trained to perform upper- and middle-management duties so that the institutions can meet their recruitment needs:
  - Phase I: 2003-2004 (senior managers)
  - Phase II: 2004-2006 (middle managers)

7.3.4 Attract and train new human resources

Targeted results

- Working conditions and conditions of practice that are better suited to the needs and values of young workers.
- Recruitment of young workers to fill the new positions.

Proposed actions

- Promote the disciplines where shortages are particularly acute, in high schools and colleges and at certain education fairs, targeting both students and career counsellors.
- Continue our involvement in the Employment Guide, which is an excellent way to reach young people who are looking for a career direction.
- Conduct an advertising campaign directed at young people and people living around Montreal presenting the Montreal region as an attractive place to work.
- Be an environmentally-responsible employer by setting up a travel management centre (alternatives to single-occupancy automobile travel) in co-operation with the Agence métropolitaine de transports.
- Support innovative programs to change working conditions and conditions of practice to bring them more in line with the values of young people (e.g.: balance between work and family life, continuing education, empowerment, technological environment, etc.).
- Study the possibility of offering different working conditions in certain job categories.

Proposed actions (continued)

- Since Montreal is a multicultural region, encourage the institutions to take advantage of the Equal Access to Employment Act (Bill 143) to recruit in the ethnic communities, where there are thought to be a large number of job seekers.
- Publicise the institutions' success stories in their efforts to attract new staff.

Support for practical training programs

Targeted results

- An effective regional coordination mechanism.
- An increase in the number of institutions offering practical training programs.

Proposed actions

- Set up a regional practical training program coordination mechanism in cooperation with our partners in education.
- Equip the regional network with an information system to more effectively track and coordinate practical training applications and openings.
- Provide incentives to senior staff to organise practical training and teaching activities.
- Use new approaches and flexible schedules to allow for practical training programs all year long.

Developing mentorship

Targeted results

- Retention of senior staff so that they can transfer their expertise before retiring.
- Proper supervision for all newly hired employees and employees with less than two years of experience.

Proposed actions

- Set up regional teams of mentors who can act as multiplying agents in the institutions.
- Implement the mentorship program in 2004-2005 in the short-term hospital centres.
- Extend the program to the whole network in 2005-2006.

7.3.5 Supporting skills development

Targeted results

- Develop a skills development plan aligned with the strategic objectives.

Proposed actions

- Draw up a skills development plan aligned with the objectives ultimately agreed upon in the 2003-2006 strategic plan.
- Organise interactive training activities on the integration of services and activities to develop shared skills needed to work in a network setting.

7.3.6 Increasing staff retention and well-being at work

Targeted results

- Increased availability and motivation of nurses in the sensitive sectors.
- Decreased work team turnover.

Proposed actions

- Financially support the specialty training of nurses to increase the availability and motivation of nurses in sensitive areas like emergency.
- Obtain funding to purchase technological equipment and tools in order to:
  - lighten the workload;
  - make work more rewarding;
  - reduce the amount of time required to perform tasks;
  - reduce the amount of spent moving around; and
  - increase job satisfaction.
- Set up control groups:
  - of young nurses to identify the conditions of work and practice that would facilitate their retention or return to the Montreal network; and
  - of nurses who are no longer working in a health care institution but continue to practice their profession (through agencies) to identify facilitating conditions of work and practice that might attract them back into the Montreal network.
- Inform the partners of the possibility, within the applicable legislative limits, of defining rules that allow for mobility between accreditations within the same institution.
- Set up inter-institution projects to guarantee the institutions a stable amount of work done, and for salaried employees, a number of days of work that better suits their needs.
- Financially help the institutions initiate innovative work time reorganisation projects to retain staff and improve conditions of practice.
- Identify the irritants in the collective agreements and make the appropriate recommendations to the negotiators.

Create stimulating and motivating working environments

Targeted results

- Slower growth of salary insurance costs.
- Reduced absenteeism.
- Review of the institutions' benefit plan management practices.

Proposed actions

- Financially support innovative prevention projects that act on the key determinants of health, (e.g.: good life hygiene, physical exercise, social and psychological support, etc.).
- Financially support innovative projects that reduce work-related risks, which have impacts on mental health.
- Equip managers to more effectively detect the warning signs in staff members who may be prone to absenteeism.
- Give financial incentives to institutions that succeed in reducing salary insurance costs and demotivation.

7.3.7 Motivating human resources

Targeted results

- Measurable human resource motivation objectives.
- Incentives to reach the objectives.

Proposed actions

- Incorporate measurable human resource motivation objectives and incentives into the management agreements with each of the institutions.
- Support skills development in line with the priorities of the 2003-2006 strategic plan.
- Provide tangible recognition of success.
- Develop a regional human resource motivation strategy.

7.3.8 Supporting change and organisational development

Targeted results

- Successful implementation of the changes foreseen in the 2003-2006 strategic plan.

Proposed actions

- Provide the required resources and expertise required to support the planned changes throughout the development and deployment of the major projects in the 2003-2006 strategic plan.
- Provide the organisational development resources required to support the small institutions in the implementation of changes or major projects.
- Identify the projects that will need support for change and organisational development.

The various components of the Human Resource Availability and Motivation Plan represent non-recurring expenditures of $26.6M.

Additionnal financial resources required

7.3 Ensuring the availability and motivation of human resources

		NEEDS (M$)		
		Recurring	Non-recurring	Capital expenditures	Indexation
7.3.1	Adopting an integrated human resources plan		3.8		
7.3.2	Rethinking the organisation of work		3.5		
7.3.3	Ensuring management succession		5.2		
7.3.4	Attracting and training new human resources		8.2		
7.3.5	Supporting skills development		0.4		
7.3.6	Increasing staff retention and well-being at work		3.6		
7.3.7	Motivating human resources		0.7		
7.3.8	Supporting change and organisational development		1.2		
Total			**26.6**		

Various complementary funding sources can be used to finance the Human Resources Development and Motivation Plan.

The main funding sources being considered are:

- existing human resource retention and job security programs and human resource training;
- subsidies from other Ministries or agencies;
- self-financing, through the purchase of services by institutions;
- the allocation, on a non-recurring basis, of a percentage of the development budgets that will be received and distributed between 2003 and 2006.

Funding sources

	Amount to be funded: $26.6 M Non-recurring
- Self-financing by the user institutions: - support organisational development, local human resources plans, training for senior management succession	- $5.1 M
- Regional envelope for job stability and security	- $5.7 M
- Regional supervisory staff development budget	- $1.5 M
- Subsidy from the Ministry of Transport	- $0.2 M
- Non-recurring allocation, for three years, of a percentage of service increases	**-$14.1 M**

7.4 Providing the information systems and technologies professionals need to work as a network and to manage on the basis of accurate, up-to-date data

The draft 2003-2006 strategic plan calls for new forms of service organisation:

- family medicine groups (FMGs) linked to the CLSCs and the Info-Santé switchboards, accessible on a 24/7 basis;
- a network of rapid access to diagnostic services through the designation of FMGs, CLSCs or medical clinics open from 8:00 a.m. to 9:00 p.m., with access to lab and ultrasound services;
- programs and networks of integrated services for vulnerable clienteles;
- decompartmentalised inter-institution teams, especially in the youth sector.

The targeted objectives cannot be achieved without adequate IT to connect the different professionals and institutions that must cooperate in order to provide continuous quality services to the population. Networking requires standardised communication tools and protocols that enable the service providers to communicate with each other effectively, efficiently and securely.

7.4.1 Computerise 58 family medicine groups (FMGs)

Targeted results

- Computerisation of the FMGs.
- Implementation of electronic connections with the FMGs.

Proposed actions

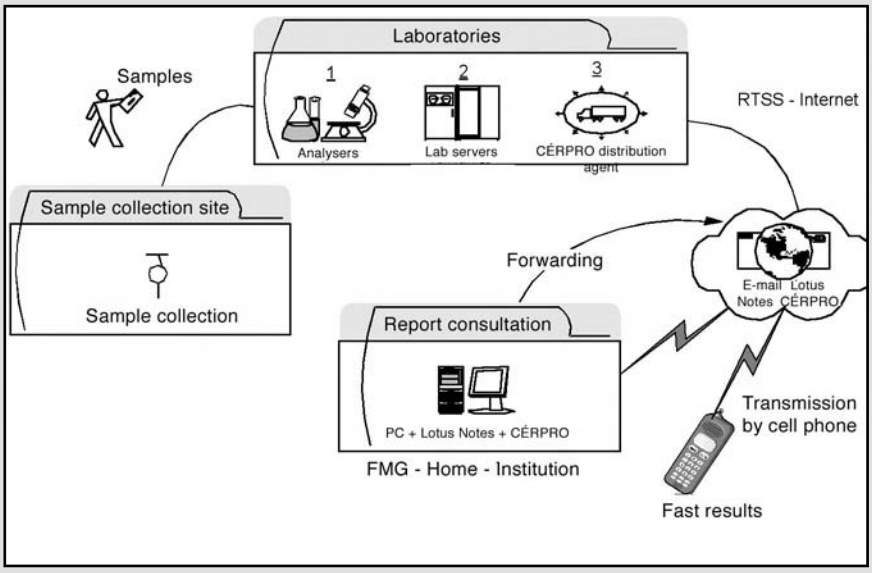
- Network the required workstations and servers.
- Install basic applications such as:
  - Office
  - Lotus Notes
  - Norton Antivirus
  - Secure Remote Client
- Install high-speed Internet connections.
- Install administrative and clinical applications.

Proposed actions (continued)

The initial phase of the plan calls for the following applications:

1. On-line registration of patients with the *Régie de l'assurance maladie du Québec*
2. Electronic connection with a central 24/7 Info-Santé hotline and the network:
   - transmission of the list of on-call physicians;
   - access to the computerised directory of health and social service resources;
   - inclusion of the vulnerable clienteles in the 24/7 Info-Santé hotline services;
   - implementation of the Inter-Institution Service Requests (IISR).
3. Install CÉRPRO (electronic results filer for professionals), or any other application considered at least as functional, to provide access to lab test results.

   Integration of CÉRPRO Courrier: How it works



4. Prescribing physicians and the pharmacological assistant:
   - the FMG draws up the patient's initial pharmacological profile;
   - the FMG can record the patient's allergies, intolerances or pathologies;
   - the FMG can record new prescriptions for the patient that instantly update the patient's profile;
   - the program checks each new entry to detect possible drug interactions, allergies, intolerances or counter-indications for particular pathologies;
   - the program provides the user with detailed print-outs for each medication;
   - the program allows the user to print out instructions for the patient.

Proposed actions (continued)

- Train and support users.

  The Regional Technology Centre will act as the one-stop provider for the training (Windows, Lotus Notes, browser) and the first level of service.

  If necessary, communications will take place with a second level of service depending on the application (Sogique, RAMQ, private provider).

  Funding for the first phase will come for the most part from the Ministry. The funding plan covers:

  - the equipment;
  - the training and support for users;
  - essential clinical applications for treatment;
  - the telecommunications links; and
  - the maintenance and updating of the clinical solutions.

7.4.2 Equip the network with rapid access to diagnostic services and the required IT

Targeted results

- Rapid access to first-line diagnostic services.
- Electronic transmission of requests and results.

Proposed actions

- Install the required hardware at the designated points of service.
- Deploy the applications and train the users.
- Make arrangements to have the points of service supported and maintained by the Regional Technology Centre.
- Identify the investments required to ensure that the production centres offer the desired level of access and availability of clinical information.
- Work with the Ministry to deploy regional infrastructures, particularly the patient index and the regional clinical data warehouses.

7.4.3 Deploy the electronic version of the Inter-Institution Service Request (IISR), the Birth Registration Notices (BRN) and the Multi-Clientele Evaluation Tool (MCET)

Targeted results

- Clientele is ensured of ongoing care at the end of a care episode.
- Continuity of perinatal services.
- A single, standardised tool to evaluate clients who are no longer fully self-sufficient.

Proposed actions

- Get the Ministry to declare the Inter-institution Service Request (IISR) "of common interest" and to provide funding for provincial deployment, support and ongoing development.
- Proceed with the regional deployment of the IISR, initially in the hospitals and CLSCs, and then in all of the institutions.

  This kind of tool has to be deployed quickly and in a synchronised manner so that the institutions are not forced to maintain parallel manual (fax) and electronic (IISR) transmission-reception systems.
- Deploy the Birth Registration Notice in the region's birthing hospitals and CLSCs and at the Department of Public Health and the Registry of Civil Status.
- Support the deployment of the electronic version of the Multi-Clientele Evaluation Tool as soon as it becomes available.
- Synchronise the deployments with the neighbouring regions (Laval, Laurentians, Lanaudière, Montérégie) in view of the number of people who live in the area served by Montreal's hospitals.

7.4.4 Implementation of an emergency department information system in all hospitals equipped with emergency rooms

Targeted results

- Access to relevant information that will help identify effective means of reducing the length of emergency department stays.

Proposed actions

- Facilitate the deployment of information systems in the emergency departments of those institutions that are not yet so equipped. To that end, secure the necessary guarantees of funding from Quebec City and supplement it with a regional subsidy.
- Promote a standardised approach that will give the region more leverage to continue upgrading the management tool chosen by as many institutions as possible, while avoiding the increased costs of upgrading a variety of competing products from different vendors.
- At the Board's expense, deploy in all of the institutions concerned a standardised data warehousing tool that would facilitate the institutions' retrospective analysis and provide the Board with an anonymised copy of the same information.
- Develop specific regional-level expertise in the analysis and interpretation of the available data and indicators, and support the individual analysis of institutions and the comparison of their management methods.

7.4.5 Initiate and complete the deployment of the priority province-wide systems

Targeted results

- Deployment of the priority province-wide information systems completed.

Proposed actions

- Complete the deployment of the PIJ information system for services for young people with adjustment problems.
- Initiate the deployment the service access management system (SGAS) in cardiology and radio-oncology.
- Complete the deployment of the blood management system (SIIATH).
- Complete the deployment of the residential centre information system (SICHELD).

7.4.6 Equip the region with a regional intranet

Targeted results

- A regional intranet that enables:
  - exchanges of clinical and administrative information;
  - decision-making support tools;
  - data warehouses; and
  - communities of practice.

Proposed actions

- Develop an overall vision shared by targeted health and social services players in the region.
- Develop and pilot-test a prototype intranet that offers the desired set of components and functions.
- Garner support from the managements of the institutions for the federating and unifying role of a regional intranet.
- Complete the implementation of the intranet and publicise its operating procedures and management framework.

7.4.7 Equip the region with a health and social services information clearinghouse

Targeted results

- Improved access to information through:
  - the integration of the analysis and interpretation of community health data into data processing activities (validation, storage, non-duplication); and
  - the management and organisation of the various information banks available in the network.

Proposed actions

- Finalise the clearinghouse project after consulting with the regional partners.
- Revise the initial Regional Information Centre project accordingly, and define the implementation phases on the basis of the agreed-upon priorities.
- Implement the clearinghouse using the infrastructure of the Regional Technology Centre.

The clearinghouse would facilitate access to the various related Information Centres in Montreal, Quebec, Canada and the world.

The financial requirements for certain information-related projects are either already included in the proposed priorities for 2003-2006, or already have guaranteed funding:

- computerisation of the FMGs;
- computerisation of the points of service of the diagnostic services rapid access network;
- development of the regional prototype intranet;
- deployment of the electronic version of the Inter-Institution Service Request (IISR) and Birth Registration Notice (BRN);
- establishment of a health and social services information clearinghouse.

Several deployments have already benefited from province-wide funding plans (computerisation of the laboratories, PIJ, SICHELD, SIIATH, SGAS, SIURGE). During the consultations on the 2003-2006 strategic plan and the drafting of management agreements between the Ministry and the Regional Board and between the Board and the institutions affected by these projects, the additional financial impacts, including the recurring support and maintenance costs, should be validated or identified.

Major decisions on the horizon

What happens in the area of information systems will be affected by a number of imminent decisions that will have major structuring effects.

The future of the health card project

The development of a management information system in the hospitals

The development of a province-wide and regional information systems architecture based on the recommendations of the Auditor General.

7. 5 Maintaining and strengthening the strategic partnerships within the Montreal community

The Regional Board and the institutions cannot improve the health and the well-being of Montrealers on their own. Success will occur through the creation of effective partnerships with the key players in the Montreal community, in the public, private, community and social economy sectors. In our discussion of the proposed priorities for the 2003-2006 strategic plan, we have already identified the social development partnerships with the City of Montreal we intend to strengthen in an effort to reduce the impact of social inequalities on health through preventive actions and to come up with appropriate solutions to Montreal's social problems. More specifically, following the signing of the City Contract, we recognise the priority intervention zones identified by the City and are committed to an integrated territorial approach in these sectors. We also plan to broaden our cooperation in social and community housing for elderly people who are no longer fully self-sufficient.

The education community

Similarly, we are working with the school boards to develop, with other partners like the CRDIM, community organisations and the City of Montreal, a plan regional that promotes persistence in school, academic success and support for drop-ins. We have already identified cooperative efforts with the colleges and the universities in our strategy to ensure the availability of competent and motivated human resources. In addition to our major project to set up integrated university health networks (IUHNs) with the McGill University and the Université de Montréal, we are considering the actions following:

Targeted results

- Decisions and practices based on accurate, up-to-date data.
- Expansion of the life sciences sector.

Proposed actions

- Integrate university research projects that can inform the decision-making process relating to the objectives of 2003-2006 strategic plan.
- Encourage the dissemination of research findings relating to the objectives of the 2003-2006 strategic plan.
- Work with the levers at our disposal to help expand Montreal's life sciences and technologies evaluation sector.

Additionnal financial resources required

7.5 Maintaining and strengthening the strategic partnerships within the Montreal community

		NEEDS (M$)			
		Recurring	Non-recurring	Capital expenditures	Indexation
7.5.1	Increased funding in support of the overall mission of the community organisations	11.3			
Total		**11.3**			

7. 6 Developing a funding strategy to optimally manage resources and delivering on the 2003-2006 priorities for health and well-being improvement

To carry out the 2003-2006 strategic plan and reach the targeted objectives, we will need an additional recurring sum of $366.5M annually by 2005-2006.

We will also need $142.4M over three years on a non-recurring basis. Investment requirements specifically related to delivering on the 2003-2006 priorities are estimated at $177M, particularly for emergency department renovations, the establishment of the FMGs, emergency department computerisation and the deployment of electronic tools to support the integrated services networks.

Additionnal financial resources required

To deliver on the six main priorities for Montreal 2003-2006		NEEDS ($M)			
		Recurring	Non-recurring	Capital expenditures	Indexation
5.1	Reducing the impact of social inequalities on the health through effective prevention initiatives	42.0			
5.2	Working in partnership to come up with appropriate solutions to Montreal's social problems	31.7			
5.3	Developing a tight-knit network of first-line services around the family medicine groups (FMG)	64.8		29.0	
5.4	Ensuring access to medical and hospital services within the recommended timeframes	17.2	110.5	127.6	91.7
5.5	Developing programs and integrated networks of services for vulnerable clienteles	153.5	11.5	20.4	19.4
5.6	Adopting regional service organisation plans in four priority sectors	46.0			
Sub-total		**355.2**	**122.0**	**177.0**	**111.1**

To deliver on our management challenges for 2003-2006		NEEDS ($M)			
		Recurring	Non-recurring	Capital expenditures	Indexation
7.1	Implementing new management tools designed to produce results measured against predefined objectives, transparency and accountability: - management agreements - a balanced assessment of performance		6.3		
7.3	Ensuring the availability and motivation of human resources		14.1		
7.4	Providing the information systems and technologies professionals need to work as a network and to manage on the basis of accurate, up-to-date data				
7.5	Maintaining and strengthening the strategic partnerships within the Montreal community	11.3			
Sub-total		**11.3**	**20.4**		
Total		**366.5**	**142.4**	**177.0**	**111.1**

How can we finance the strategic plan within the budget granted by the Ministry?

Possible funding strategies

1. Optimally manage the current budget of $4B and make selective use of the indexation of expenditures we are able to get over the next few years

In its action plan "*Making the right choices*", the Ministry recognises that to keep pace with the increase in costs specific to the health and social services sector, an indexation rate of 2.6% should be applied to the known common costs of other sectors of activity in Quebec.

This indexation would cover the increase in service volumes generated by the ageing of the population, technological change and rising drug costs.

Indexation of 2.6% would represent, for the region, an additional recurring budget of $107M in 2003-2004, $214M the following year and approximately $321M in 2005-2006.

Value in millions of dollars of various rates of indexation over and above the base rate of 2.6% covering increases in salaries and miscellaneous expenditures

	2003-2004	2004-2005	2005-2006
0.5 %	20.7	41.4	62.1
0.7 %	29.0	58.0	87.0
0.8 %	33.1	66.2	99.3
0.9 %	37.2	74.4	111.6
1.0 %	41.3	82.6	123.9
1.5 %	62.0	124.0	186.0
2.6 %	**107.0**	**214.0**	**321.0**

Delivering on our priorities would take $111.1M out of the indexed amount. If we get 2.6%, 35% would have to be allocated for that purpose.

The required sum of $111.1M corresponds roughly to an indexation rate of 0.9%, which would give us an additional $111.6M in 2005-2006. This would make the priorities feasible on the condition that the additional indexation, beyond the indexation to cover increases in salaries and other expenses, be somewhere between 0.9% and 2.6%. Getting a rate of 2.6% would also enable us to pay down the structural deficit of Montreal's institutions over a three-year period.

We estimate the budget deficit of Montreal's institutions at $140M for 2002-2003. This deficit is concentrated in the large university hospitals, which provide to the bulk of specialised and ultraspecialised medical services whose volumes we want to significantly increase to ensure access within the recommended clinical timeframes.

A sizeable portion of the deficit is due to under-indexation in previous years, and another part is linked to the difficulties the institutions have experienced in controlling their expenditures. The Regional Board estimates the structural deficit of its regional network at $100M, of $40M could be absorbed through more stringent cost control.

Roughly 30% of the structural deficit is due hospital services rendered to people from other regions of Quebec. This factor needs to be taken into consideration in applying the indexation rate.

With an indexation of 2.6%, we could absorb the structural deficit in three years, and still have about $70M of recurring funds left over to cover increases such as rising operating costs due to the introduction of equipment and the installation of equipment that will be delivered between now and 2006. These costs are estimated at $28.7M a year and are related to the projects presented in Appendix 8 of Support Document.

2. Obtain a non-recurring budget increase of the sort proposed in the Ministry's *"Making the right choices"* action plan to ensure access to specialised medical services

The Ministry has recognised the need for a non-recurring expenditure of $162M to improve the access to these services throughout Quebec.

Given that the Montreal region accounts for about 60% of the Quebec's population, and that Montreal serves part of the neighbouring regions in the identified priority sectors, we could reasonably expect to get $65M of that amount over a three-year period to complete funding for the increased volume of services.

Since we have patients receiving targeted interventions, about $40M of that would pay for the additional services required by Montrealers and $25M to provide the same services to people from other regions. These proportions reflect Montreal's share of the Quebec population and the size of the clientele receiving this type of services from Montreal hospitals, as we noted in Chapter 5.

3. Obtain a recurring budget increase of $366.5M over a three-year period

In *"Making the right choices"*, the Ministry estimated the additional funding needs at $1.6B. The additional $366.5M required in Montreal is consistent with the needs of the Montreal population, which makes up 25% of Quebec's population, and with Montreal's socio-economic characteristics and the particular urban social issues it is faced with. Montreal also provides a significant level of supra-regional services that have an impact on the access of Montrealers to specialised and general medical services.

4. Reallocate the institutions' current resources to the priority actions agreed upon in the management agreements

The consultation and the management agreement process should be seen as an opportunity to determine to what extent the network's current resources can be reallocated to accomplish certain priorities, rather than relying solely on a recurring increase from the Ministry.

More specifically, we need to assess our ability to do the following:

- lengthen the hours of operation of the CLSCs;
- develop an integrated mental health services networks;
- produce a regional service organisation plan for persons with physical disabilities; and
- produce a regional service organisation plan for persons with intellectual impairment.

5. Identify ways to deliver on the priorities for less than the estimated cost

For example, the proposed concentration of cataract surgeries and hip and knee replacements should result in a reduction of unit costs. Similarly, some community support services could be provided at higher than current levels by giving allowances directly to the users, a measure which would alleviate staff shortage pressures in certain cases. Also, it costs less to develop social housing with community services for some types of vulnerable clienteles like the frail elderly than to focus as much as we do on institutional residential services.

6. Self-finance certain priorities through loan authorisation or non-recurring initial budgets

This strategy could be considered in the case of the regional residential services organisation plan we will be drafting in 2003-2004. That would enable us to get a head start on develop alternatives housing in institutions, and then reallocate resources from the obsolete institutional facilities users would be moved out of.

This approach could be combined with a private sector or not-for-profit partnership to develop and manage the new residential facilities, freeing the network to concentrate on its primary mission of providing health and social services to people who are no longer fully self-sufficient

7. Finance the non-recurring expenditures needed to deliver on the priorities out of the requested budget increases

These expenditures are estimated at $142.4M. If we subtract $65M from the $162M identified in *"Making the right choices"* to improve access to specialised medical services, we still need to get $77.4M from the recurring increases, which should reach $366.5M a year in 2005-2006.

Given the magnitude of our plan, which implies the integration of thousands of new people into the regional network, and especially into the CLSCs, we will have to consider gradual implementation, perhaps over more than three years, and properly prepare the terrain in terms of work organisation and human resource management. This is the sector where most of the non-recurring expenditures are planned, with the exception of the money needed to create a transitional fund to adjust the supply of emergency services to the seasonal variations in demand. We will continue to need this fund until the reorganisation of first-line services has been completed and has started to produce the expected effects.

8. Establish an order of priorities

The coming budget increases will obviously be spread out over several years. One of the purposes of the consultation is establish an order of priority based on our ability to act and on the impact of planned actions on the maintenance and improvement of the population's health and well-being.

If we get a first instalment of $60M to $100M, to which priority should it be allocated? If the recurrent funding is less than $366.5M, which projects should be given priority? These questions point to the importance of coming out of this consultation with an order of priority that will enable us to proceed with the best possible project given the resources available, whether the resources come from an increase or through reallocation.

9. Accomplish certain priorities in five years

In view of the scope of our project to make fundamental changes in the way first-line services are organised, it would perhaps be wise to make the strategic decisions now and secure the funding quickly, while extending the implementation of certain priorities over five years.

This slower pace would increase the chances of success by giving the service providers more time to properly organise their human, material and informational resources.

Bringing over 4,000 new people into the Montreal network is a major challenge, given the current work organisation structures, the shortages of personnel in certain sectors and the modifications that will need be made, particularly to buildings and computer systems.

10. Adopt strategic plans for capital expenditures, equipment and IT resources

The extent to which workplaces and technologies are appropriately organised and used will have a significant effect on the achievement of our objectives in service delivery and physician and human resource motivation.

Our present equipment assets are valued at $1.1B, and they will require major replacement and development investments in the years to come. Funding to provide technical aids for daily living and domestic activities will necessarily have to increase given the major developments that are going to occur in home support services. It will also be necessary to invest to improve the conditions of practice of the care unit and living unit staff by providing such aids as electrically-adjustable beds, patient lifters, etc.

We will also have to plan the introduction of high-tech equipment like positron emission tomographers (PETs) within the province-wide and regional priorities.

We will have to review the current strategy of maintaining our regional real estate assets, which have a replacement value of $4 billion but a maintenance budget of only $14.6M a year. Finally, once the 2003-2006 strategic plan has been adopted, we will have to draw up a capital expenditures master plan and review our current real estate development priorities (see Appendix 9 of Support Document).

On the IT systems and technologies front, once the 2003-2006 strategic plan is in place, we will have to develop an IT business plan as recommended by the Auditor General.

The Montreal region network owns an impressive amount of IT technology and systems. According to a recent survey of the region (RESIR), there are close to 30,000 workstations, nearly 10,000 printers and some 1,000 servers of all types.

To these investments, we have to add infrastructure and networking equipment costs, as well as the costs of purchasing office automation programs and the whole range of clinical or administrative applications. The picture gets more complicated because, for lack of specific funding, a number of institutions have turned to leasing and outsourcing arrangements which include a high asset depreciation component. The investment can be reliably estimated at about $200M, but the average lifespan of most of the equipment rarely exceeds 5 years. In other words, the Montreal region network will have to invest about $40M to maintain these assets.

The question is not should we spend money maintaining our assets, but whether or not would it be useful to set up a regionalised asset maintenance fund, similar to the ones for real estate and medical equipment, as opposed to ensuring

funding by assigning a percentage of the operating budgets and systematically allocating to it a percentage of all development budgets received in the future, as we do for furniture, equipment and the rental of space

Last but not least, the institutions have identified development needs in excess of $130M that they would like to deal with over the next three years. Over 75% of the planned developments are in the clinical information systems, radiology, patient files, laboratories and technologies; cost-wise, 90% of these projects are in hospitals, and half are in the region's three UHCs.

Consequently, in addition to the projects that relate directly to the specific objectives of the 2003-2006 strategic plan, we will have to adopt a strategic IT development plan that lays out the priorities and funding strategies in this area for the years to come.

8.
Conclusion and questionnaire

The goal of this consultation is to validate the proposed priorities, their relative importance, the value of the targeted results, our ability to achieve them through the proposed actions, and the proposed strategies for medical staffing and human, material, IT and financial resources by May 2003.

We are calling upon the Montreal community to help improve the initial propositions and build a strong consensus in favour of the 2003-2006 Montreal Improvement Plan for Health and Well-being, that the Board will adopt next June, at the same time as the Montreal Public Health Action Plan.

Once adopted, these plans will have a determinant impact on:

- the resource allocation priorities;
- the management agreements between the Regional Board and the Ministry and between the Board and Montreal's institutions; and
- the projects to be carried out with our regional partners.

Montreal Priorities 2003-2006

1. **Reduce the impact of social inequalities on health through effective prevention actions**
2. **Work with partners to come up with appropriate solutions to Montreal's social problems:**
- young people with adjustment problems
- violence
- prostitution
- homelessness
- lack of social housing
- compulsive gambling
- alcoholism and drug addiction

3. **Develop a tight-knit network of first-line services around the family medicine groups (FMGs)**
4. **Ensure access to medical and hospital services within the recommended timeframes:**
- equip Montreal with a network of rapid access to diagnostic services open from 8 a.m. to 8 p.m., 365 days a year, 7 days a week
- concentrate cataract surgeries and hip and knee replacements in designated centres

5. **Develop programs and networks of integrated services for vulnerable clienteles:**
- elderly people who are no longer fully self-sufficient
- people with evolving chronic diseases (chronic obstructive lung disease (COLD), heart failure, diabetes)
- cancer patients
- people with AIDS
- the mentally ill
- people with pervasive developmental disorders (PDD)

6. **Adopt regional service organisation plans in four priority sectors:**
- residential and long-term care services
- services to people with physical deficiencies
- services to people with intellectual impairment
- perinatal services.

Questions

- Are the six proposed priorities relevant?
- Do the targeted results in each of the priorities justify the proposed actions and the required resources?
- Is the proposed allocation of additional resources between the different priorities justified?
- Which of the proposed actions are you interested in being involved in, and in what way?

Montreal Challenges 2003-2006

1. **Implementing new management tools designed to produce results measured against predefined objectives, the transparency and the accountability:**
   - the management agreements with the institutions
   - a balanced assessment of results and performance
2. **Ensuring the availability and motivation of physicians**
3. **Ensuring the availability and motivation of human resources**
4. **Providing the information systems and technologies professionals need to work as a network and to manage on the basis of accurate, up-to-date data**
5. **Maintaining and strengthening the strategic partnerships within the Montreal community**
6. **Developing a funding strategy to optimally manage resources and deliver on the health and well-being improvement priorities for 2003-2006.**

Questions

- Are the six proposed priorities relevant?
- Do the targeted results in each of the priorities justify the proposed actions and the required resources?
- Is the proposed allocation of additional resources between the different priorities justified?
- Which of the proposed actions are you interested in being involved in, and in what way?

A territorial approach to intersectoral coordination and service integration

1. **The Montreal Public Health Action Plan and the region's municipal, school and health & social services districts**
2. **Health & social services integration and coordination and territorial divisions**

Questions

- Are the proposed solutions relevant?

Lexicon

Commission Clair: Quebec Commission of inquiry on health and social services.

Commission Romanow: Commission on the Future of Health Care in Canada.

First-line services: First-line services are the point of entry into the health care and social services. They include all routine medical and social services that rely on a non-equipment-intensive diagnostic and therapeutic infrastructure capable of dealing with most of the common social and medical issues and problems of the population.

General practitioners FTE clinical: A FTE is a volume of services equivalent to the typical workload of a physician dispensing clinical services on a full-time basis. For example, the population of Montreal is served by 1,747.4 general practitioner FTEs. The actual number of general practitioners in Montreal is 2,190.

Intermediate resources: Any resource associated with a public institution which, in order to keep or to integrate a registered user in the community, uses the resource to provide a living environment consistent with the user's needs as well as the support or assistance required by his/her condition.

Ministry: Quebec Ministry of Health and Social Services.

Orphaned patient: A person who does not have a family doctor.

Priority intervention zones: Zones identified by the City of Montreal and the Government in the City Contract, as warranting a specific and complementary effort by the government and the City, in areas such as land use planning, housing, public facilities, social development, education and employment.

Second-line services: These are social and medical services designed to solve complex problems, including assistance, support and accommodation services and a range of specialised services that rely on an adapted infrastructure and, in the case of medical services, on diagnostic and therapeutic technologies that are equipment-intensive but widely available.

Third-line services: Third-line services are ultraspecialised medical services for people with either very complex or very uncommon health problems.

Vulnerable clienteles: Mostly but not exclusively elderly people who are weakened as a result of one or several acute or chronic pathologies that are often debilitating and unpredictably progressive. These people may also be suffering from one form or another of cognitive impairment.

AUC: Affiliated University Centre

CHR: Rehabilitation Hospital Centre

CIHI: Canadian Institute for Health Information

CLSC: Local Community Services Centre

COLD: Chronic Obstructive Lung Disease

CPDP:	Council of Physicians, Dentists and Pharmacists
CRDIM:	Conseil régional de développement de l'Île de Montréal
CYPC:	Child and Youth Protection Centre
DRMG:	Regional Department of General Medicine
DSP:	Director of Professional Services
ECG:	Electrocardiogram
FMG:	Family Medicine Group
FMOQ:	Quebec Federation of General Practitioners
FMSQ:	Quebec Federation of Medical Specialists
FMU:	Family Medicine Unit
FTE:	Full-Time Equivalent
GSHC:	General and Specialised Hospital Centre
HIV:	Human Immunodeficiency Virus
IHG:	Interdisciplinary Health Group
IT:	Information Technology
MSSS:	Ministry of Health and Social Services
PHC:	Psychiatric Hospital Centre
PREM:	Regional Medical Staffing Plan
PROS:	Regional Medical Services Organisation Plan
PROSEM:	Regional Service Organisation and Medical Staffing Plan
RAC:	Regional Administrative Conference
RC:	Rehabilitation Centre
RLCC:	Residential and Long-Term Care Centre
RMC:	Regional Medical Commission
RMDC:	Regional Multidisciplinary Commission
RNC:	Regional Nursing Commission
RTSS:	Health and Social Service Telecommunications System
UHC:	University Hospital Centre
WHO:	World Health Organisation
YC:	Youth Centre

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