

Summary

Action for Access

Montreal Organisation Plan for General Medical Services and Medical Staffing

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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,



David Levine
President and Executive Director

The present document is a summary of the Montreal Organisation Plan for General Medical Services and medical staffing, "Action for Access" (*Plan montréalais d'organisation des services médicaux généraux et des besoins en effectifs médicaux*), a consultation paper that is recommended by the Regional Department of General Medicine (DRMG). This summary presents the major issues, anyone interested in reading the plan in its entirety is invited to consult the last page of this summary for the necessary information. All information regarding the Regional Board's consultation process can be found on the Regional Board's website: www.santemontreal.qc.ca





INTRODUCTION

In accordance with the “*Act respecting health services and social services*”, the Regional Department of General Medicine (DRMG) must define and propose a plan for the organisation of general health services and for the required medical staffing. In addition, the DRMG must see to the implementation and administration of this plan once it has been adopted.

This is the framework in which the **Montreal Organisation Plan for General Medical Services and medical staffing, “Action for Access”**, was developed. The plan has been presented to general practitioners for the purpose of consultation. The cooperation of general practitioners is essential to the pursuit of the objectives set out by the Regional Board, particularly as they pertain to access to general health-care services and organisational models for service delivery, which are prior conditions for the implementation of a solid primary-care network in Montreal.

Goal: To Improve the Organisation of Primary Health-Care Services

In collaboration with all general practitioners throughout our territory and our partners in the health-care system, the DRMG would like, first and foremost, to work toward the construction of a functional and accessible primary-care network with a perspective towards managed, continuous care and service.

If they are to be effective and efficient, general practitioners must have access to diagnostic techniques, to specialised expertise, and to all professionals working in the system. In addition, a functional network rests upon the implementation of a clinical and administrative information system.

Guiding Principle: Patients As Our Major Concern

- ▶ Empowerment
- ▶ Continuity of care and services
- ▶ Comprehensive care: to prevent, to cure and to treat
- ▶ Accessibility
- ▶ Establishing priorities for health care and services
- ▶ Inter-professional and inter-institutional collaboration.

An Integrated Network

An integrated network is made up of people, organisations, and institutions that work toward a common goal and whose different components (material, financial, and human resources) constitute a whole.

This network must involve all general practitioners who are members of the DRMG working within the territory of the Montreal Regional Board and who provide primary-care services, no matter where they practice: CLSCs, medical clinics, doctors’ offices, family-practice units, residential and long-term care centres, rehabilitation centres, or any new or future organisational structures for providing services, such as family medicine groups or network family medicine clinics (called *pivotal clinics*).



The Mission of an Integrated Network

The network's mission will be to provide the territory's entire population with a complete range of short- and long-term, primary health care and services, including preventive and diagnostic services, treatment, rehabilitation, and palliative care. This network should be all of the following: universal, free of charge, comprehensive, continuing, homogeneous, efficient, of high quality, and accessible in terms of geography, physical barriers and schedule.

Territorial Breakdown

Organising a general-care network aimed at linking services as closely as possible to citizens' natural and usual environments meant dividing Montreal into sub regions. This territorial breakdown must respect the citizens' natural habits and patterns when consulting health-care services and respect the existing collaborative organisations that function well. The territory of Montreal has therefore been broken down into six sub regions, grouping different CLSC territories, for the purpose of planning primary health-care services. None of these sub regions is off limits for other citizens or physicians, and each sub region should provide the population with well-organised, general, primary-care services.



* In response to requests made by these two CLSCs, we recommend that the CLSC Parc Extension now be included in the Centre-West sub region and that the CLSC Saint-Louis du Parc now be part of the Centre-East sub region.



Access to Diagnostic Services

Given the needs identified by the physicians who are members of the executive committee of the Montreal DRMG, general practitioners within the territory must possess the tools needed to respond to the requirements of their clinical role. In general terms, this means the following:

- ▶ Basic blood, microbiological, and cytological sampling;
- ▶ Medical imaging, including examinations based on x-rays, fluorescent x-rays, ultrasound (including Doppler imaging), CT scans, MRIs, and bone scans;
- ▶ Electrophysiology examinations such as ECGs (resting, stress-test monitoring, thallium, MIBIs), EMGs, and EEGs;
- ▶ Respiratory-system analysis.

In order to offer efficient primary-care services, expected and proposed waiting times are the following:

Less than 24 hours for urgent situations:

- Meaning the same day; results should be sent to the physician requesting them within two hours of a test.

From one to five days for semi-urgent situations:

- Results should be sent to the requesting physician on the day of the test.

From one to four weeks in elective situations:

- Results should be sent to the requesting physician within one week or less.

▶ Recommendations

To guarantee the degree of accessibility needed to ensure that patients' health problems will be well managed, we recommend the following:

1. In collaboration with institutions and non-institutional clinics, the Regional Board should develop an action plan to provide technical support that can respond to the needs of a well-organised, primary-care network throughout the territory on an expanded, seven-day-a-week schedule, taking into account the clinical situations described above: urgent, semi-urgent, and elective.
2. The Regional Board should enter into service agreements with non-institutional clinics so as to ensure that all patients will have access to technical support at no additional expense.
3. The Regional Board should provide all physicians with a list of locations where such services are available within the prescribed time periods.
4. The joint follow-up committee, representing the DAMU, CMR, and DRMG¹, should be able to provide the Regional Board with advice on what action to take, given the identified limitations, so as to equip the primary-care network with the tools required to carry out its role in accordance with the different clinical situations occurring throughout the territory.
5. Computerisation of the network and modern communications technologies should be used to support organisational efforts related to the delivery of primary health-care services.

1 | Department of medical and university affairs, Regional Medical Commission, Regional Department of General Medicine



- ▶ 6. The Montreal Regional Board's department of medical and university affairs (DAMU) should request that the Collège des médecins du Québec, in cooperation with different institutions involved in medical training (universities, professional associations and federations) take part in optimising the appropriate use of technical support facilities for the following purposes: pre-doctorate training; continuing medical education; and designing, updating, and disseminating instruction manuals.
- 7. The Regional Board, in collaboration with the health-care institutions and clinics affiliated via service agreements, should promote the implementation of an evaluation mechanism that would make it possible to react efficiently if the time needed to access technical support facilities were to become unacceptably long.
- 8. The Regional Board should submit an annual report to the CMR and DRMG on how the above recommendations have progressed.

Access to Specialized Health-Care Services

Montreal's general practitioners regularly raise two major issues concerning specialized medicine:

- ▶ Access to specialists (waiting periods and a lack of information on how to locate them);
- ▶ Communication of results, treatment plans, or follow-up plans following initial or later visits.

Recommended solutions for facilitating access to specialised health-care services:

Semi-Urgent Situations (1 to 5 days)

Some specialists, including internists, cardiologists, respirologists, and gastroenterologists, are asked to respond to semi-urgent situations, which often require the more complex technical support generally available in hospitals. It is therefore necessary to provide for the following:

- ▶ Access to outpatient clinics or ambulatory centres with blocks of time reserved both for new patients and for those with worsening conditions;
- ▶ Optimal efficiency at hospital outpatient clinics, including measures to ensure that visits by new patients are confirmed and that all visits are tightly managed;
- ▶ Proper availability of technical support for consultant physicians;
- ▶ Rapid communication of results and treatment plans to requesting physicians following medical visits: the same day, if the patient is immediately returned to the care of a general practitioner, and within a week or less, in all other cases.

Selective Situations (1 to 4 weeks)

Elective visits concern all clinical specialties. Visits may be made to a physician's office, a clinic, a CLSC, or an ambulatory care centre, depending on how each specialty is organised. Adequate access means the following:

- ▶ Easier arrangements for making appointments;
- ▶ Blocks of appointment times for new patients;



- Optimal appointment management, especially in hospital outpatient clinics;
- Appropriate availability of technical support for consultant physicians;
- Communication of results, treatment plans, and follow-up plans to the requesting physician within one week or less.

► Recommendations

To guarantee the degree of accessibility needed to ensure that patients' health problems will be well managed by general practitioners, we recommend the following:

1. The Montreal Regional Board should place a high priority on computerising the locations where requesting and consultant physicians are visited, providing the necessary links with the health and social services telecommunications network.
2. The Montreal Regional Board should immediately request that the institutions on its territory optimise their use of modern communications technologies (fax machines and secure e-mail systems) and of clerical support staff needed by health specialists to send relevant information to requesting physicians. The board should also support said institutions in this endeavour.
3. The Regional Board's DAMU should request that the Collège des médecins du Québec become involved in enhancing information exchanges between consultant specialists and requesting physicians. This means providing precise requests with all relevant information as well as consultant clinical reports that are as informative as possible regarding investigation, treatment, and follow-up plans, in addition to progress reports with subsequent test results.
4. In collaboration with the institutions, the Montreal Regional Board should promote the use of a standardised form for summarising medical information when a patient is released from hospital. This form should include a copy for the user and/or the attending physician and an original to be kept in the patient's file. The latter would replace the summary sheet currently used in our institutions. (This kind of form could also be used for patients examined and treated in emergency departments.)
5. The Regional Board should draw up a list of locations where specialised services are available within the established waiting periods and inform all physicians of its existence. (This could be done in stages, one sub region at a time.) The board should also ensure that this information is periodically updated.
6. The Regional Board should request that the associations of medical specialists and departments of professional services in general and specialised hospital centres (CHSGSs) on our territory help to decide upon means for removing obstacles to access in the different sub regions.
7. In collaboration with the institutions, the Regional Board should promote the implementation of a monitoring mechanism that would make it possible to react efficiently if waiting times for appointments in specialized outpatient clinics become unacceptably long.



Current Situation of Family Medicine in Montreal

General practitioners work in many fields, including geriatrics, obstetrics, perinatal care, teaching and research, hospitalisation, mental health, public health, occupational health, palliative care, intensive care, and home care. Although we should hope that general practitioners will continue working in the above fields, their main role is to provide their clients with care, treatment, and follow-up. Therefore, we must succeed in establishing a general, primary-care network of services that will provide our population with a reliable safety net. We are at a crossroads, and several of the items below offer us food for thought.

Findings

Those Served and Their Needs

- ▶ Growing needs in a population of 1,838,472 residents and approximately 350,000 non-residents:
 - The oldest population in Québec
 - Areas of great poverty
 - A lack of patient management
 - Clients at risk, including 35,000 patients who have no family doctor
 - Important issues: mental health, homelessness, polysubstance abuse, HIV.
- ▶ The net annual increase in the number of people residing on the Island of Montreal is 15,000.
- ▶ Access to care and treatment and to walk-in services are legitimate expectations of the population.

Medical staffing in Montreal

- ▶ There are major human-resource problems in general medicine throughout Quebec, including Montreal.
- ▶ The region of Montreal has many specialists, but their services are not provided only to people living in the city. Between 25 and 30 per cent of the primary- and secondary-care services delivered by specialists in hospitals are for people living in the areas surrounding Montreal.
- ▶ Primary care has become fragile and therefore vulnerable. Clinics have closed.
- ▶ The DRMG is responsible for regional medical staffing plans (PREM in French) and the regional organisation of services (PROS in French). It should be understood that medical personnel working in private offices and clinics are now part of the Medical staffing plan.

Organisation of Services

- ▶ There is a precarious situation in emergency departments. The Ministry of Health and Social Services and the Regional Board want steps to be taken so that emergency departments can run more smoothly.
- ▶ The shift to ambulatory care remains incomplete. Primary care services, having not been made a partner in this major change, was therefore not ready to withstand the shock.



- ▶ Fragmented time blocks:
 - Especially during times considered to be unfavourable;
 - Points of care are open an average of 56 hours per week;
 - CLSCs provide complementary support to general medical emergency ambulatory services, especially outside regular hours.
- ▶ Two major issues: suitable access to diagnostic technical support and to timely appointments with specialists.
- ▶ There is consensus regarding the role of primary care as the foundation of the health-care system.
- ▶ The Ministry of Health and Social Services intends to reorganise primary-care services, particularly by supporting the establishment of family medicine groups.

ORGANISATIONAL MODEL

Family Medicine in Montreal's Future

We cannot look to the future without counting on the existing offices, clinics, and CLSCs. These points of care respond to the changing needs of our clients. However, new avenues can also be explored: family medicine groups and network family medicine clinics, known as pivotal clinics.

Family Medicine Groups (*Groupes de médecine de famille « GMF » en français*)

The DRMG's executive committee wants to encourage physicians to work together, and family medicine groups provide an avenue for this. What follows is the executive committee's opinion on how a Montreal family medicine group should function.

A group would be formed with enough general practitioners to offer a defined range of services based on personalised care. The majority of the group's physicians would make their participation in the group their principal activity and would be the basic nucleus of the group. They would provide their clients with comprehensive and continuing care and services. We are in favour of a mutual accountability and loyalty agreement between the patient, on the one hand, and the attending physician and the group, on the other hand.

As concerns the scope of primary-care services, such a group, in collaboration with other health-care professionals, would provide promotion and prevention services, in addition to curative and palliative services. Particular attention must be paid to clients at risk. These would be defined and well identified. These clients include elderly persons who are no longer self sufficient, people with serious mental-health problems, with complex and chronic diseases, and patients requiring palliative care. Such clients are often registered in a CLSC home care and support program.

Ideally, the scope of services offered will correspond to those needed by people throughout their entire lifetime. Services will be available seven days a week by appointment or on a walk-in basis. The group will organise its services so that they respond on a daily basis to the urgent needs of its patients. To ensure that its clients will have access to treatment and care, the group may take part in an access network in cooperation with other health-care professionals in the same area. The group will make home visits and will remain on call for persons living at home with seriously reduced independence as well as for those who are frail or need palliative care.



The group's physicians will work in cooperation with nurses and other health-care professionals, including social workers, dietitians, physiotherapists, occupational therapists, psychologists, and pharmacists. Under the supervision and coordination of physicians, nurses will take part in activities related to education, prevention, management of complex health problems, and case management. They will also coordinate linkage activities with secondary-care services, CLSCs, and other institutions.

A family medicine group will establish a mechanism for evaluating the quality and efficiency of the organisation of its services. It must be integrated into the regional organisational plan for general health-care services of its DRMG.

The Ministry has decreed several basic principles and conditions for accrediting family medicine groups:

- ▶ Registration of all patients is fundamental.
- ▶ The group must remain on call 24 hours a day, 7 days a week, for its clients at risk.
- ▶ All participating physicians must sign an agreement.
- ▶ The group and the CLSC must sign a protocol agreement.
- ▶ The Regional Board and the group must sign a contract agreement.
- ▶ The Ministry of Health and Social Services is responsible for accrediting a family medicine group, authorizing its technical and financial support, and transferring budget allocations for the group to the Regional Board, which is then responsible for distributing them.

Network Family Medicine Clinics, Called Pivotal Clinics

Given its 29 CLSCs, 175 clinics, 10 family medicine units, 210 private offices, and many different time schedules for services, people in Montreal have a hard time understanding the system. On the one hand, even with well-structured entities such as family medicine groups, no one would imagine that all such points of care could work long hours 365 days a year. On the other hand, several time periods remain uncovered in some sub regions.

Therefore, we believe that it is important to set up a truly accessible network with approximately 40 network family medicine (pivotal) clinics included in our points of care. CLSCs and family medicine groups will, of course, be able to become involved in this network and be recognised as points of care. However, medical clinics will constitute the bulk of these points of care, given that they currently provide the great majority of general health-care services during difficult hours.

Our objective is to set up 40 family medicine clinics, one for every 50,000 people. They would remain open on a walk-in basis from 8 a.m. until 9 p.m., 365 days a year.

Such a network would provide the population with a genuine safety net. We are convinced that it would also enable emergency departments to run more smoothly because they could use their specialised services and expertise more judiciously.

However, we do not intend to set up specialised walk-in institutions. Although it is very useful, the walk-in option should not become the foundation of family medicine. The majority of physicians at all general-medicine points of care should see these points as their main hub of activity, and the great majority of their clinical activities should be devoted to the care and treatment of clients with appointments, not only to care episodes but also to preventive activities, regular



follow-up, and periodic examinations. Special attention should be paid to clients at risk. Furthermore, pivotal clinics should manage their clients at risk, and the latter should be clearly identified and registered with their attending physicians within the group. This should be the situation for our future pivotal clinics.

Such network (or pivotal) clinics must sign a service agreement with the Regional Board via its DRMG. The services offered and visiting hours would be stipulated in the agreement. For the vast majority of these clinics, hours would be extended, in some cases as much as 50 per cent. This requires administrative support from the Regional Board. Furthermore, these clinics should be connected to the Quebec health and social services telecommunications network so that information such as lab analyses and consultant clinical reports can circulate more smoothly.

Technical Support

In the Montreal area it is difficult and sometimes impossible for patients to have a simple blood count done on a weekday afternoon or to have an urgent ultrasound unless they are willing to pay for it in a private clinic. The great majority of people with these kinds of needs therefore end up in emergency departments.

We propose the creation of emergency sampling centres with the required testing equipment in pivotal clinics. In addition, from 8 to 10 of these 40 clinics should be provided with ultrasound equipment. Such centres already exist in the private system, and a service contract could be signed with the Regional Board for a certain number of urgent ultrasound tests, which would be covered by the public system. The primary-care network would thereby be well prepared to assume its responsibilities, and the population would be better served with respect to both primary- and secondary-care services.

OUR PRIORITIES

Overall Objective

Our overall objective is to establish an integrated network of primary health-care services, capable of providing access, 365 days a year, to comprehensive care and treatment, as well as to continuity of care, for the entire population. This network is to be created by promoting and supporting efforts to bring together existing health-care resources.

Action Plan

- ▶ To promote and support general practitioners who would like to work together in accordance with the proposed organisational models.
- ▶ To promote cooperation among the different medical organisations so as to create an integrated access network.
- ▶ To develop clinics capable of providing complete technical support in each sub region and of serving as points of care that will be accessible to all general practitioners and their patients in the sub region.
- ▶ To develop service agreements between all points of general health care and their network partners (CLSC professionals, hospital ambulatory care centres, radiology clinics, and specialised health-care resources) so as to facilitate patient access to all necessary resources.



Specific Objective

To ensure care and treatment, within each sub region and from a perspective of complementarity with the network, for clients at risk and with reduced independence due to aging or to chronic or terminal diseases.

Action Plan

- ▶ To establish - within family medicine groups and in cooperation with the network - the professional resources needed to provide follow-up for clients at risk.
- ▶ To identify or register at-risk clients with family medicine groups.
- ▶ To finalize the implementation of a 24-hour, 7-day-a-week nursing and medical on-call service for home-care patients and those having linkages with the Info-Santé CLSC 24/7 telephone health line.
- ▶ To design, promote, and support continuing medical training activities so as to maintain and develop the knowledge and skills of general practitioners with regard to chronic diseases, aging, and palliative care.
- ▶ To create permanent access to consultation opportunities with previously identified colleagues (general practitioners or specialists) who have expertise in the above-mentioned fields.

Specific Objective

To provide organised, primary health-care services for people with mental-health problems in the framework of shared care between general practitioners and specialised psychiatric teams. This objective entails an integrated network of continuing psychiatric care in each of the DRMG's sub regions.

Action Plan

- ▶ To create a shared-care approach to mental health with the help of specialised psychiatric teams.
- ▶ To enter into agreements with specialised psychiatric teams in each sub region for the purpose of creating an integrated network.
- ▶ To make general practitioners familiar with the shared-care model for mental health.
- ▶ To design continuing medical training activities for mental-health care.

Specific Objective

To integrate preventive clinical practices into standard medical practices.

Action Plan

- ▶ To continue to integrate and maintain preventive clinical practices in family medicine groups and other kinds of practices via the development and consolidation of practical clinical tools for patients, nurses, and physicians.
- ▶ To continue training and information activities aimed at transferring knowledge of preventive clinical practices for physicians via a medical-practice prevention program.



- To continue prevention and promotion activities in cardiovascular health care with CLSC multidisciplinary teams by means of programs such as *Au cœur de la vie* (at the heart of life).
- More specifically, in the area of infectious diseases, to cooperate in the designation of six primary-care, post-exposure points of care for the purpose of follow-up and management of patients and contacts. These should include a medical clinic, a family medicine group or a pivotal clinic, and a CLSC, which would be the entities responsible for this work in each sub region.

CHANGING NUMBERS OF GENERAL PRACTITIONERS IN MONTREAL

Primary Health-Care Activities

Data from the Fédération des médecins omnipraticiens du Québec (FMOQ) clearly shows that, between 1992 and 2001, health professionals have moved to institutions such as CLSCs and residential and long-term care centres (CHSLDs) and away from private offices and clinics: there were 107.7 fewer in full-time equivalent (FTE) positions. Given that such offices and clinics are the main entryways for providing access to health-care services, these findings are disturbing.

FTE (full-time equivalent) activities of primary-care general practitioners in the area of Montreal²

Years	Medical offices	CLSC	CHSLD	Total in primary-care activities
1992-1993	1,017.7	81.3	60.3	1,159.3
1993-1994	1,005.8	132.6	69.8	1,208.2
1994-1995	1,004.3	140.7	73.1	1,218.1
1995-1996	997.4	155.3	71.1	1,223.7
1996-1997	985.9	156.4	68.6	1,210.9
1997-1998	939.2	151.7	71.0	1,161.9
1998-1999	916.3	146.1	68.2	1,130.6
1999-2000	926.8	148.2	76.1	1,151.2
2000-2001	910.0	151.9	83.3	1,145.2

² | FMOQ, *Des omnipraticiens à la grandeur du Québec* : Évolution des effectifs et des profils de pratique -Région 06 : Montréal-Centre, juillet 2002, page 6



Secondary Health-Care Activities

Montreal's well-developed hospital network, which serves not only our own region, but others throughout Quebec as well, is one of the pillars of our health-care system. Nearly a third of Montreal's general practitioners (30.2 per cent) work in secondary care. This increase in secondary care has occurred at the expense of emergency treatment, whereas their presence in hospitalisation has stabilized. It is essential to maintain a balance so as to avoid a disruption of services.

FTE (full-time equivalent) activities of second-line general practitioners in the area of Montreal³

Years	FTE in CHSGSs in the Montreal area	FTE hospitalisation in the Montreal area	FTE emergency	% in secondary care
1992-1993	520.00	174.49	170.19	29.7
1993-1994	525.40	180.38	178.37	29.8
1994-1995	526.04	173.91	185.50	29.6
1995-1996	515.42	162.49	183.42	29.2
1996-1997	490.11	165.70	173.77	28.4
1997-1998	473.75	158.50	176.49	28.4
1998-1999	459.67	157.78	180.76	28.3
1999-2000	476.68	165.24	191.58	28.6
2000-2001	511.21	181.37	205.73	30.2

Our Needs in Terms of General Practitioners

We must define Montreal's need for health services in terms of how human resources are broken down into primary and secondary care and other issues that characterize our territory.

Given that we lack validated field data, our main sources of information are the Ministry and the FMOQ.

If we use the calculation method proposed by the FMOQ, we see that the FTE shortage of general practitioners in Montreal is 188:

- Shortage of primary-care general practitioners = 135
- Shortage of emergency-department general practitioners = 16
- Shortage of secondary-care general practitioners = 37

³ FMOQ, *Des omnipraticiens à la grandeur du Québec* : Évolution des effectifs et des profils de pratique -Région 06 : Montréal-Centre, juillet 2002, page 6



However, we believe this shortage to be about 315 FTE general practitioners, not 188. Our calculations take into account the actual population to be serviced; weighting factors related to the age, gender, and socio-economic situation of Montreal's population; and the number of general practitioners working in public health and education.

Regional Medical staffing Plan

We are aware that the province's shortage of health-care resources will require some difficult decision-making, and we would like to distribute medical personnel as fairly as possible without depriving Montreal of its fair share. In the current situation, successfully organising a functional primary-care network by making use of the health-care resources available in our region will not be enough to maintain what has already been obtained in secondary care, unless additional resources are made available.

The planning and management of our human resources must be adapted to the reality of our situation via the collaboration of all those concerned, and we must all share the same objective of responding as best we can to our population's health-care needs by taking into account our established priorities, namely:

- ▶ To develop a regional medical staffing plan in accordance with the guidelines of the Ministry and the needs of our region and to make management rules known;
- ▶ To update and evaluate the need for general practitioners in all the institutions of our region so that we can determine which institutions and priority sectors have genuine, immediate needs for health human resources. This should be done in the following order:
 - 1) General and specialised hospital centres (CHSGSs)
 - 2) CLSCs and private offices
 - 3) Residential and long-term care centres (CHSLDs) and psychiatric hospital centres (CHSPs)
 - 4) General and specialised hospital centres with a rehabilitation mission, rehabilitation centres, etc.;
- ▶ To establish criteria for medical staffing needs and distribution in accordance with the reality of our region so that we can safeguard what has been achieved and ensure that there will be no disruption of services in secondary care;
- ▶ To identify and list specific health-care activities and priority sectors so as to support the work of secondary-care general practitioners without weakening primary care;
- ▶ To implement reorganisation of primary care and evaluate human-resource needs so as to ensure access, care and treatment, and continuity of the health services best adapted to the needs of the population;
- ▶ To adapt the regional health human-resource plan to the organisation and medical staffing plans of the institutions and to the DRM's Montreal plan for the organisation of health services.



DECIDE - ACT - EVALUATE - ADJUST

The following is a passage quoted from the report by the Commission d'étude sur les services de santé et les services sociaux (task force on health and social services), entitled *Les solutions émergentes* (emerging solutions):

“A new theme should quickly spread throughout the system: Decide, act, evaluate, adjust. That would make the difference between a system going round in circles with a few token pilot projects that end up being forgotten and one that gradually implements a new means of organising its services.”

This is the mental framework with which we would like to contribute to organising a network of general primary health-care services and in which this document has been written. We want to ensure that its development will be managed dynamically.



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« L'accès en actions » - Résumé



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