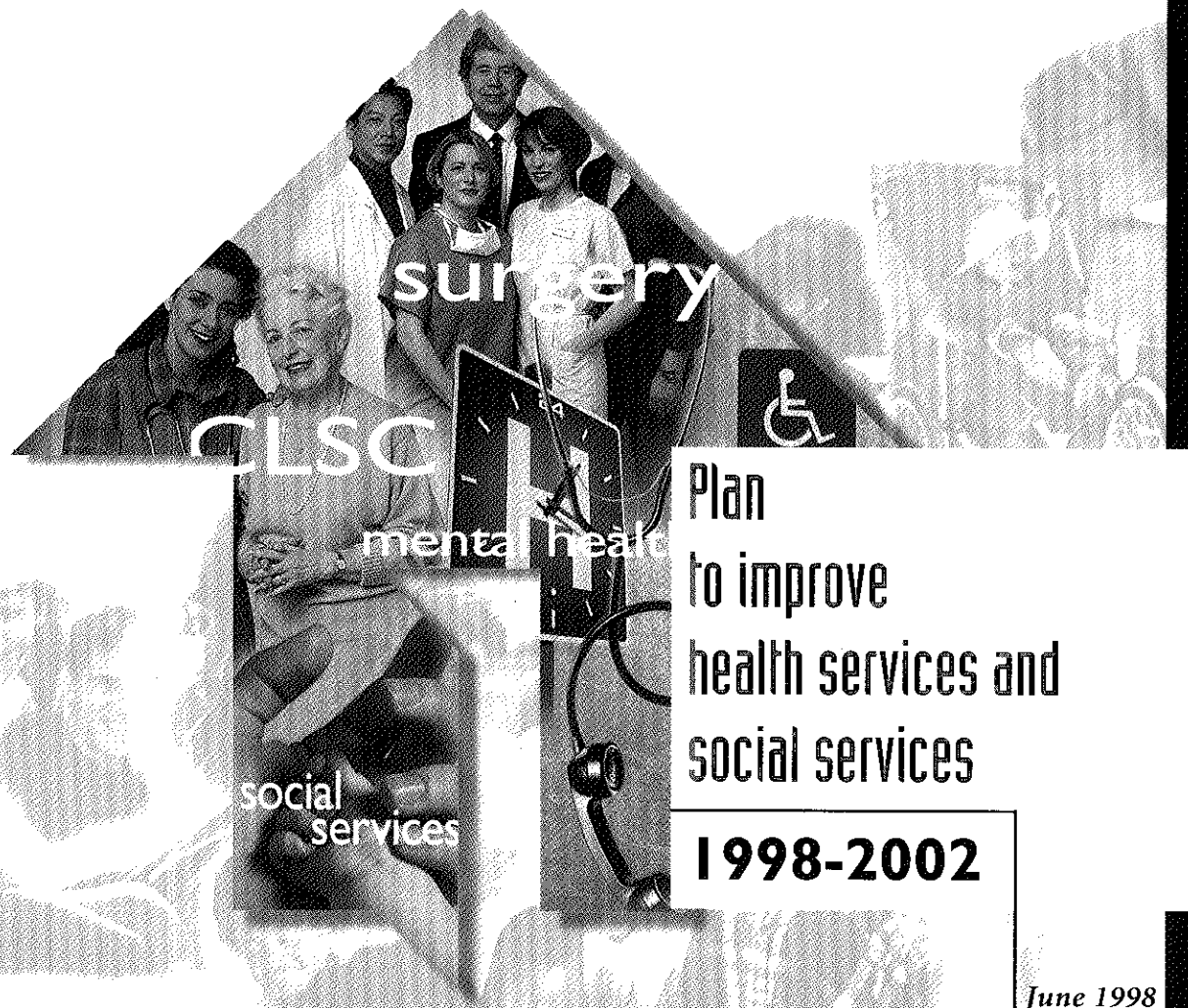
RÉGIE RÉGIONALE
DE LA SANTÉ ET DES
SERVICES SOCIAUX
MONTRÉAL-CENTRE



Plan to improve health services and social services

1998-2002

June 1998

Accent on Access

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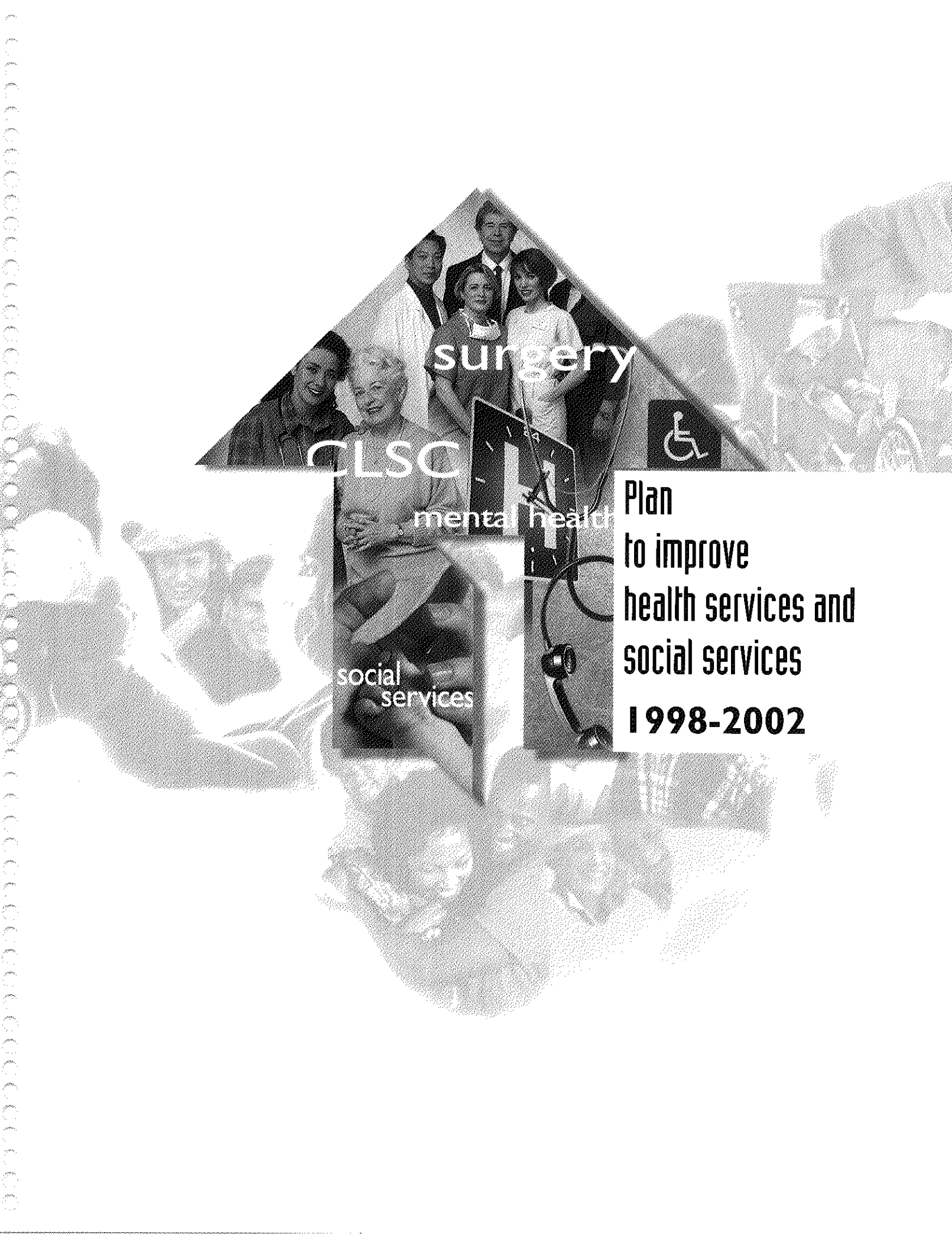

Plan to improve health services and social services

1998-2002

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GLOSSARY

AIDS . . . . . .Acquired immune deficiency syndrome

CIDA . . . . .Canadian International Development Agency

CDPQ . . . .Caisse de dépôt et placement du Québec

CECM . . . . .Commission des écoles catholiques de Montréal (Montreal Catholic School Board)

CESAM . . .Coopératives d'établissements publics pour des services administratifs de mise en commun (public insitution cooperatives for pooled administrative services)

CH . . . . . .Centre hospitalier (hospital)

CHR . . . . . .Centre hospitalier de réadaptation (rehabilitation hospital)

CHSGS . . .Centre hospitalier de soins généraux et spécialisés (General and specialized care hospital)

CHSLD . . .Centre d'hébergement et de soins de longue durée (residential and long-term care centre)

CHSP . . . . .Centre hospitalier de soins psychiatriques (Psychiatric hospital)

CHU . . . . . .Centre hospitalier universitaire (University hospital centre)

CHUM . . . .Centre hospitalier de l'Université de Montréal (Hospital of the Université de Montréal)

CLSC . . . . .Centre local de services communautaires (local community service centre)

CPEJ . . . . . .Centre de protection de l'enfance et de la jeunesse (Youth and child protection centre)

CQCS . . . . .Centre québécois de développement et consultation sur le sida (Quebec AIDS development and consultation centre)

CR . . . . . .Centre de réadaptation (rehabilitation centre)

CRAN . . . . .Centre de recherche et d'aide aux narcomanes (Centre for drug addiction research and assistance)

CRPDI . . . .Centre de réadaptation pour personnes atteites de déficience intellectuel (Rehabilitation centre for people with intellectual impairments)

CRPDIPT . .Centre de réadaptation pour personnes atteintes de déficiences intellectuel, physique et de toxicomanie (Rehabilitation centre for drug addicts with intellectual or physical impairments)

CSN . . . . . .Confédération des des syndicats nationaux (Confederation of provincial unions)

CTMSP . . .Classification par type en milieu de soins et services prolongés (Classification according to type in extended care environments)

DMP . . . . . .Département de médecine préventive (Department of preventive medecine)

DPJ . . . . . .Direction de la protection de la jeunesse (Youth Protection Department)

DSC . . . . . .Département de santé communautaire (Community health department)

EFT . . . . . .Equivalent full time

FMOQ . . . .Fédération des médecins omnipraticiens du Québec (Federation of general practitioners of Quebec)

FSSS . . . . . .Fédération de la santé et des services sociaux (Federation of health and social services)

FSTQ . . . . .Fonds de solidarité des travailleurs du Québec

GL . . . . . .General laboratory

GRIS . . . . . .Groupe de recherche interdisciplinaire en santé (Interdisciplinary health research group)

GSL . . . . . .General and specialized laboratory

HEC . . . . . .Hautes études commerciales

HIV . . . . . .Human immunodeficiency virus

HMO . . . . .Health Maintenance Organizations

IDU . . . . . .Injectable drug users

IFR . . . . . .Intensive functional rehabilitation

IFRU . . . . . .Intensive functional rehabilitation unit

IRM . . . . . .Institut de réadaptation de Montréal (Montreal rehabilitation institute)

ISP . . . . . .Individualized service plan

MDA . . . . . .Mesures de départs assistés (Assisted departure measures)

MED-ECHO Maintenance et exploitation des données pour l'étude de la clientèle hospitalière (Maintenance and use of data for hospital clientele studies)

MIF . . . . . .Mesure d'indépendance fonctionnelle (Functional independence measurement)

MRC . . . . . .Municipalité régionale de compté

MSSS . . . . .Ministère de la Santé et des Services sociaux du Québec (Department of health and social services)

MUC . . . . . .Montreal Urban Community

MUHC . . . .McGill University Health Centre

OHA . . . . . .Ontario Hospital Association

OPHQ . . . .Office des personnes handicapées du Québec

ORL . . . . . .Oto-rhino-laryngology

PLAISIR . . .Planification informatisée des soins infirmiers requis (Computerized planning for nursing care requirements)

POSILTPH .Programme de services à domicile intensifs à long terme pour les personnes handicapées physiques (Intensive long-term home care services for the physically handicapped

RAMQ . . . .Régie de l'assurance maladie du Québec

RIASG . . . .Réseau intégré d'accessibilité aux soins généraux (Integrated network for access to general care)

SGF . . . . . .Société générale de financement du Québec

SIC . . . . . .Système d'information-clientèle (clientele information system)

SICC . . . . . .Système d'information clientèle CLSC (CLSC clientele information system)

SIPA . . . . . .Services intégrés aux personnes âgées en perte d'autonomie (Integrated services for the elderly experiencing a loss of autonomy)

SISMAD . . .Système d'information sur les services de maintien à domicile (Information system on home-care services)

SRMO . . . . .Service régional de main-d'oeuvre (Regional manpower department)

SSP . . . . . .Services de santé du personnel (Personnel health services)

STD . . . . . .Sexually transmitted diseases

UHC . . . . . .University hospital centre

UHRESS . .Unité hospitalière de recherche et d'enseignement socio-sanitaire (Socio-sanitary research and teaching hospital unit)

UAC . . . . . .University affiliated centre

UQAM . . . .Université du Québec à Montréal

INTRODUCTION

On September 25, 1997 the Régie régionale de la santé et des services sociaux de Montréal-Centre decided to initiate a process designed to provide the regional network with an integrated plan of action of the years 1998-2002.

To this end, the Board of Directors formed a Committee composed of seven members of the Board: Mrs. Colette P. Chagnon, Mrs. Jenny Goldman and Messrs. Pierre Berger, Robert Bousquet, Guy Breton, Jacques Foisy and Horace-Alain Sirois, as well as Doctor Marc-André Asselin, President of the Commission médicale régionale. The Committee also included two ex-officio members: Messrs. Conrad Sauvé, Chairman of the Board, and Marcel Villeneuve, Executive Director. On April 30, Mrs. Kathleen Weil replaced Mr. Sauvé as Chairman of the Board of Directors. Mr. Robert Bousquet was appointed Chairman of the Committee.

The Committee's mandate is as follows:

To recommend to the Board of Directors:

- an integrated document on the consolidation of health and social services for the 1998-2002 period;
- a consultation process, adapted to the elements contained in the consolidation plan;
- a communications strategy for network and intersectoral partners, the media and the population;
- a plan of action in regard to the decision-making process, implementation and follow-up of the plan;

and to provide the Board of Directors with:

- regular reports on the progress of the implementation of the various measures adopted, difficulties encountered, suggested solutions and adjustments which should be made to the plan.

The challenge is to choose and implement solutions for the future which will maintain and consolidate the balance between the needs of the population and the quality and quantity of services and enable a number of improvements to be made, carefully targeted according to their importance to the population. This process demands that we employ the full potential of the necessary resources and conditions available.

In order to support this regional process, in January of this year, the Régie régionale undertook a major consultation procedure with the following objectives:

- to seek as general a consensus as possible in regard to the choice of priorities to improve services and
- to solicit the participation of the necessary partners so that the solutions for the future retained could be implemented.

In order to facilitate understanding of the issues involved in the process and to encourage the participation of groups and organizations concerned by the plan to improve health services and social services for 1998-2002, the Régie régionale de Montréal Centre produced and distributed a series of five (5) consultation documents: the consultation paper, ***Accent on access***, presenting all the measures proposed and the principal issues, a consultation support paper containing a detailed report on the results of the plan to reorganize services initiated in 1995 and the measures proposed for the period 1998-2002, two (2) explanatory summaries, one covering the measures proposed concerning ***Human resources*** and the second on the plan to ***modernize administrative and support services*** and lastly, an information document for the population, ***Accent on access: 13 ways to improve access to our health and social service network***.

The public consultation was initiated on January 15, 1998 with the distribution of the consultation paper to all the partners and groups concerned by the plan to improve health services and social services for 1998-2002. The objectives of this consultation were:

- to inform the Committee responsible for the process and the Board of Directors on the suggestions made and opinions expressed by all interested publics;
- to gather the opinions of the interested publics and invite them to comment on the proposals and recommendations submitted for consultation;
- to enable all interested parties to contribute to improving the initial proposal by suggesting changes to the proposals submitted for consultation, until their adoption;
- to establish consultation activities adapted to the target publics and the consultation topics.

With this goal in mind, the Régie régionale de Montréal-Centre undertook the activities required to consult the various target publics, particularly the general population,

users' committees, network partners and the many groups and organizations interested in the consultation.

The results of this consultation enabled the Régie régionale to take a precise reading of the vision of the groups consulted and to revise the plan to improve services in light of the proposals and comments submitted.

1 SUMMARY REPORT ON THE CONSULTATION ACTIVITIES

PUBLIC CONSULTATION ACTIVITIES

From March 9 to 12 and on March 18, 1998, the Régie régionale de Montréal-Centre held five (5) days of public hearings on its three-year plan, Accent on Access, which proposes a series of measures to improve health services and social services on the Island of Montreal.

The Committee of the Board of Directors responsible for the consultation process received 174 written notices, 121 of which were also presented orally. The public hearings were televised live with the participation of Videotron.

In addition to the public hearings on the overall plan to improve services for 1998-2002, the Régie régionale organized topical consultation activities including, on March 12, 1998, a regional forum on youth services which reached 79 participants from the sectors concerned. A regional forum intended for users' committees on March 16, 1998 brought together 76 participants representing 36 users' committees from all categories of institutions. The Régie régionale also invited experts and interested groups and organizations to participate in a day of public hearings on February 27, concerning emergency services, during which 14 written notices were presented.

The Régie régionale collected comments from the population through a survey carried out between February 27 and March 11, 1998 involving 1,000 respondents on the Island of Montreal. An information document and a questionnaire were also prepared and distributed on request, while an interactive information document and a questionnaire on the Régie régionale's proposal was posted on the Régie's Internet site so that individuals could submit their comments.

KEY POINTS RAISED IN THE NOTICES AND COMMENTS

- **Survey**

The survey revealed that, when presented with concrete solutions (regional priorities for 1998-2002), the population consulted expressed a widespread degree of optimism and commitment to the plan to improve services for 1998-2002. However, it appears that the availability of human and financial resources in the network is a concern. In terms of improving services, hospital emergency departments headed the respondents' list. Of the measures proposed to improve services, those which received the most attention on the part of the population concerned services to youth experiencing difficulties and the elderly.

- **Questionnaire**

Thirty-five (35) completed questionnaires were returned to the Régie régionale. For the most part, services to youth, the elderly and, more generally, the availability of medical services retained the respondents' attention. The interactive questionnaire accessible on the Régie régionale's Internet site did not provide the anticipated results. No-one made use of it.

- **Regional forum on behalf of the users' committees**

There was a general consensus that the quality of services was a major concern. Continuity of services was also raised as being a problem. The participants expressed a wish for improvements to be made in the coordination of services and communications between organizations. For the residents of residential and long-term care centres, two major elements were raised: food should be considered a clinical service and not a support service and the term "user" should be changed for the term "resident".

- **Regional forum on youth**

One of the first points which emerged from the discussions with the participants was the lack of common objectives and a common vision of the situation experienced by youth and families. In the participants opinion, the second aspect of the problems faced by youth services is the lack of continuity and coordination of services due, in part, to a lack of regional leadership and coordination. Possible solutions were, however, suggested, including clarifying the roles and mandates of the institutions, improving the integration of services and linkages with partners, having the Régie régionale assume regional leadership, increasing funding and improving the methods of allocating resources.

- **Hearings on emergency services**

The consultation revealed that a consensus exists among the partners in regard to adopting an overall approach targeting the network since the problem in emergency departments is considered as being systemic. The main solutions mentioned

concerned access to family physicians, medical specialists and laboratory services. The need to improve the distribution of ambulances and the manner in which the institutions process requests from the emergency rooms were also mentioned.

- **Public hearings**

After analyzing the comments and notices received, it appears that the general orientations, particularly the metropolitan vision, network approach and public nature of services which underlie the Régie régionale's proposal were well received by our partners. According to certain groups, the general orientations must include teaching and research.

To varying degrees, all the participants in the public hearings proposed improvements and modifications concerning the means of action, financial resources or even the conditions for performance presented in the consultation paper. This document has been revised in the light of these proposals.

The following are the key points raised during the public hearings:

Medical practice: The challenge will be the organization of first-line services and, in particular, the sharing of responsibilities between private medical clinics and the CLSCs. The creation of the département de médecine générale (Department of general practice) and the abolition of the punitive decree for new physicians are two conditions essential to the plan's performance. The involvement of the medical specialists must also be sought in order to improve continuity and access to services.

Physical health: Proposals concerning the organization of ultra-specialized services, improvement of emergency services and the organization of first-line medical services met with a favourabnle response among the population as well as the participants in the consultation.

The role of the general and specialized-care hospitals and the organization model for laboratory services require clarification.

Mental health: Since Departmental orientations have not yet been confirmed, a prudent approach and requirements concerning transition funds were well received by the consultation participants.

A large part of the discussions focused on the roles and mandates assigned to the various players in the mental health field: role of the hospitals and psychiatrists, role of the CLSCs and role of the community organizations.

Clarification is required in regard to basic services in the community, Info-Santé and rehabilitation and reintegration in the community. The youth priority was well supported. Expectations were expressed in regard to clientele with multiple problems. Leadership is expected from the Régie régionale in regard to organization and follow-up of resources and services.

Intellectual impairment: Conclusions concerning the measures in this continuum were generally supported by all the consultation participants. In regard to conditions for performance, the realities faced by the beneficiaries and the quality of services to be maintained must be taken into account in implementing the proposed changes. More precise details were required in regard to data concerning waiting lists. Autism should no longer be subject to a double coordination within the Régie régionale. As for pervasive developmental disorders, the consortium's formula should be continued in the new three-year plan.

Physical impairment: Two issues were raised: major improvements were expected in the coordination of services since they are poorly linked and vary a great deal between institutions which assume the same responsibilities. The scenarios proposed concerning intensive functional rehabilitation (IFR) were not subject to a consensus among the participants.

The elderly: The adequacy of the response compared to increasing needs continues to be a concern, as do the consequences of the shift toward ambulatory care. The development of a range of resources is expected: intermediate placement, an increase in the number of care-hours for long-term beds, as well as an increase in home-care services and transport. Coordination and improved linkages between all the components are also perceived as possible solutions.

Youth: Emphasis was placed on the need for the Régie régionale to clarify roles and responsibilities in the provision of services to youth. These roles and responsibilities must be established according to a common vision of the situation experienced by youth and families. Expectations were also expressed concerning the coordination that the Régie régionale should exercise in regard to services for youth.

The homeless: The Réseau des personnes seules et itinérantes suggested introducing overall planning work as well as supporting and consolidating community action. On the operational level, the development of means of access would help to improve the situation.

Alcoholism and drug addiction: The extent of the problems justifies greater funding than currently assigned. For

methadone treatment, 2,500 heroine addicts should be targeted.

Organizations involved with clientele suffering from AIDS: Organizations must be equipped to adjust to the evolving situation and the Régie régionale must assume leadership, particularly in regard to developing a regional prevention program.

Concerning the problem related to women in general and more specifically violence against women, the recognition of shelters, as well as the CLSCs, appears to be important in specifying the roles and mandates of each. Targeting children and pregnant women victims of conjugal violence should be included as a regional priority.

It was also hoped that the feminine gender would be used in all programs and services.

The CLSCs are involved in all sectors of the proposed three-year plan. Consequently, it is not surprising to see them question the Régie régionale on many aspects of the plan. They seek an overall vision which would assign them an important role as gate of entry to the network, with the consequent funding. The differences between requests for services and resources assigned appears much too wide to enable the CLSCs to occupy the position they feel is theirs in the health and social service network. The methods of establishing efficiency and equity used by the Régie régionale were questioned.

Multi-sectoral community organizations: Recognition, respect of their independence and their budgetary consolidation appear to be the most important issues. They agree to participate in a collaborative process in so far as their participation is free and voluntary. These organizations are opposed to budget cuts in the health and social service network.

Modernization of administrative and support services
The idea of modernizing infrastructures interested several of the participants in the consultation. The cooperative formula was questioned. This procedure must remain flexible and should not become a substitute for the institutions' accountability. The objectives for results on a budgetary level must be realistic in view of the cuts that have already been made over the past few years. In regard to food, the regional proposal generated a great deal of apprehension on the part of the residents.

Health sector: an economic pole
This was not a major topic in the consultation. Of those who expressed an opinion, with only one exception, the vision of health as an economic pole was well received.

Human resources
A strong point was raised by the institutions, as well as by unions and management associations: the Régie régionale must respect local independence and must not create an intermediary level between the provincial and local authorities. However, a partnership role is anticipated. This role should come into play through the proposed work zones and, in particular those involving enrichment of the role of management personnel, professional mobility and maintaining skills. The Regroupement des organismes communautaires emphasized the importance of the principle according to which personnel may not be transferred from institutions to community organizations.

Quality improvement
The users' committees and professional orders, among others, expressed a great deal of concern in this regard. The aspect of relations with the staff in institutions, the respect of individual rights, quality and continuity of services and competence of the staff are points which the Régie régionale should consider. Severe criticism was made by a group which provides assistance and accompaniment for users submitting complaints, in regard to the quality of the mechanisms by which complaints are processed in the network.

Many submissions were made in regard to improving access to services in keeping with the multiple realities in the region: cultural and linguistic communities, homelessness, the gay and lesbian community, obesity, women, and others.

CONCLUSION

The revised plan now contains four general orientations. A key component in our mission, teaching and research, has been added to the metropolitan vision of services, the network approach and public services at the right pace.

This service improvement plan now covers the period 1998-2002 and focuses on the twelve central measures designed to introduce significant improvements in the accessibility and quality of our service continuums.

At the regional level, 49% of the plan will be self-financed. Complete performance will require recurring budgets of $147.3M for the period from 1999 to 2002. This would correspond to a 1.6% budget increase per year commencing in fiscal 1999-2000. The achievement of our objectives will also require efficiency gains estimated at $95M during the next four

years. The assumption of the increase in system costs by the Ministère de la Santé et des Services sociaux could reduce the necessary outlay to $40M.

2 CHOOSING SOLUTIONS FOR THE FUTURE: ORIENTATIONS

The Régie régionale intends to prepare its plan to improve services for the years 1998-2002 based on the following objective:

- **To maintain and improve the state of health and welfare of the population**

Our objective is to augment efforts to consolidate our services and improve the performance of the network in certain sectors which have an important effect on the health and welfare of the population. Following the public hearings, it was decided to add the field of teaching and research to the specific orientations already established.

The following orientations will guide all our actions over the next few years.

2.1 FOUR GENERAL ORIENTATIONS

2.1.1 A metropolitan vision of services

One of the characteristics of the Island of Montreal is its metropolitan role. Specialized and ultraspecialized services are offered to the entire metropolitan population and, in certain fields, to people throughout the Province.

There are 2,900,000 people living in the area between Highway 640 on the north shore and Highway 30 on the south shore, within 30 minutes of the centre of the Island of Montreal. Representing 58.7% of the population of Quebec, the five regions which make up the metropolitan zone receive 57% of the health and social service budget.

Another feature of this metropolitan zone is that there are no borders between the various sectors and that the population has free access to the specialized and ultraspecialized services in the area according its needs and without taking administrative boundaries into account, whether these services involve work, culture, education, or health and social services, etc.

The use of hospital services by the population confirms that the Montreal hospital network serves a population pool covering the entire metropolitan area.

In general, 34% of our hospital services are provided to persons who do not reside on the Island of Montreal, the large majority of whom live in Laval and outlying regions to the north and south. This percentage rises to 53% for ultraspecialized services, 36% for specialized services and is even 29% for general care.

Table 1 - PROPORTION OF HOSPITAL SERVICES PROVIDED TO PEOPLE WHO DO NOT RESIDE ON THE ISLAND OF MONTREAL

34 % of hospital services provided to non-residents
Ultraspecialized services: 53 %
Specialized services: 36 %
General services: 29 %

Table 2 - SERVICE POOLS FOR CERTAIN MONTREAL HOSPITALS	
INSTITUTIONS	% of patients from neighboring regions: Laval, Montérégie, Laurentians, Lanaudière
Centre hospitalier de l'Université de Montréal	37 %
Hôpital du Sacré-Coeur de Montréal	53.4 %
Centre hospitalier Angrignon	18.1 %
Lakeshore General Hospital	32.8 %

In view of this situation, what approaches should we take?

- **Recognition of a metropolitan space in terms of specialized services and integrated planning of the organization of services at this level**

We believe that the Department and our partners in the metropolitan region must recognize the reality of this metropolitan space and that we must work together to achieve an integrated plan of the organization of hospital services on this basis, with the objective of ensuring equity and freedom of access to services, while making the best possible use of the resources and infrastructures available for this purpose.

We must start with the reality of the metropolitan service pool, rather than dividing it up into reduced pools that would be unable to maintain the critical mass necessary to ensure the quality of specialized and ultraspecialized care.

We agree with the idea of restoring some of the balance between general-care resources and certain specialized services in the metropolitan space, providing it is performed in an integrated manner, in order to improve equity of access, quality of services and the optimal use of resources and infrastructures.

- **Identification of adequate provincial budgets to finance ultraspecialized services**

The distinctive feature of these services, such as transplantations, cardiac surgery and neurosurgery, is that their service pool includes the entire metropolitan region and, in certain cases, the entire Province.

We think that the creation of provincial budgets to finance these services would be a solution, on the condition that:

- they take into account all the costs related to these activities, including those incurred for research, teaching, administration and support services;

- that they include a balancing fund to maintain the balance between the provision of services and needs and so that ideal waiting periods for access to health services are respected.

- **Consideration of all costs in decisions concerning the planning of hospital services and rebalancing resources and services in the metropolitan area**

An integrated plan for the organization of services in the metropolitan area must be based on an accounting of all costs: transition costs, costs related to infrastructures, costs related to manpower being reassigned, costs related to the accumulated debt.

Between 1995 and 1998, the Montreal-Centre region already made an important contribution to readjusting the inter-regional balance of resources.

During this period, budgets on the Island of Montreal were subject to a net decrease of $200.3M, of which $177M was the result of six hospital closings and the conversion of another into a long-term care centre. During the same period, the regions surrounding Montreal had their net budgets increased by $30M.

In view of the major reorganization of hospital services which has just been implemented on the Island and the financial situation in which we find ourselves, we believe that the path to the future will require an integrated service organization plan in order to ensure equity and freedom of access, as well as the optimum use of our resources on a metropolitan scale.

- **Access to first-line services and residential and long-term care services at the local and regional level**

On the other hand, we believe that access to first-line services, whether they be in the field of health, social services, mental health, or home-care must be provided on a local basis in each region. The same approach must also be applied to residential and long-term care services.

Persons who receive ultraspecialized or specialized services from a hospital located on the Island of Montreal must be able to benefit from the same continuity of services whether they live in Rivière-des-Prairies, Longueuil or Laval.

While it is necessary for the services on the Island of Montreal to be joined in a network, the same is also true for several inter-dependent services at the metropolitan level.

- **Consideration of the specific characteristics of the population living on the Island of Montreal**

Because of its location in the centre of the metropolitan region, the Island of Montreal has a population with special characteristics which are generally found in major urban centre cores and which make it distinct from other regions in Quebec.

Our population is characterized by:

- **Rapid aging**

The percentage of people aged 65 or over is 14%, while it is only 10.1% in the rest of Quebec.

- **A rich and diversified linguistic and cultural mosaic**

In the other regions of Quebec, the population whose origins are French is 84.2% while the proportion on the Island of Montreal is 46.8%.

- **A high percentage of single-parent families and single people**

The proportion of single-parent families with children under the age of 18 is 24.9%, while the provincial average is 17.9%. Persons living alone represent 17.6% of the population while in the entire province the proportion is 12.1%

- **Poor neighborhoods side-by-side with high-income areas**

The proportion of persons living under the low-income cut-off is the highest in Quebec: 27.8%, while the provincial average is 19.2%. Also, in 1995, 17.5% of the population lived on social assistance benefits while the proportion for the entire province was 12.5%

- **A population with more education than the average in certain sectors and elsewhere, a high rate of school drop-outs**

The state of health and welfare of the population involves the following characteristics:

- a higher rate of infant mortality associated with a higher rate of babies with a low birth weight, particularly in the poorest sectors of the Island;
- more people with mental health problems;
- more problems related to violence against women, children and adolescents;
- more acute problems in the following fields:
  - homelessness;
  - the spread of AIDS;
  - breast cancer, considering the rate of potential years of life lost.

There is one final factor that must be considered in the role played by the Island of Montreal in the metropolitan region. The concentration on the Island of certain services in the fields of education, public transport and health and social services makes it a focal point for certain clientele, particularly persons with physical or intellectual impairments. This situation requires that adjustments be continually made in the offer of specific services required for the health and welfare of these individuals.

2.1.2 A network approach

One of the objectives that all health and social service systems must achieve is the guarantee of complete and continuous services to the population.

In several less urbanized regions in Quebec, where the administrative and geographic boundaries correspond to natural population pools, there is a trend toward administrative integration on the basis of the municipalités régionales de compté (MRCs) for first-line and placement services and on a regional basis for specialized services.

However, the Montreal and metropolitan environment has its own characteristics which require a different approach. As we have indicated, the territory contains many different players who contribute to providing a full response to the needs of the population: 150 institutions, over 400 clinics and physicians' offices, 4,500 physicians, 400 community organizations.

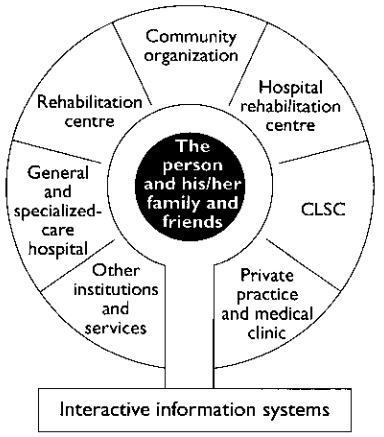
In addition, due to the mobility of the population within the metropolitan region, service pools of the various organizations intersect one another without actually being superimposed.

For example, in post-operative care, our hospitals can deal with various CLSCs on and off the Island, while different CLSCs can receive people referred by hospitals in many different locations on the Island.

So, to ensure continuity of services, in 1995, we opted for an approach adapted to our environment: an interactive network of locally independent entities.

The establishment of such an interactive network requires the contribution of all partners who respond to various aspects of the needs of an individual in a complete and continuous manner.

Table 3



Two conditions are necessary for the establishment and successful operation of a true network:

1. **Ensure that each component in the network has the appropriate level of resources to play its role;**

A network is as weak as its weakest element, or the element with the lowest performance.

2. **Establish functional interactive liaison mechanisms;**

Since 1995, we have made significant progress in organizing a network of our services in certain sectors, but a great deal remains to be done before we have a true network in all service continuums.

For example, in the post-operative and post-hospital home-care sector, we have achieved remarkable results in the past two years, following the increase of resources assigned to the CLSCs for this purpose and the improvement of liaison mechanisms between the hospitals, CLSCs and physicians.

Another sector where progress has been made is in services provided to the elderly experiencing a loss of autonomy. The CLSC now serves as a single window for access to long-term home-care services to maintain users in the community and for residential and long-term care placement services.

We have not yet managed to organize the medical clinics and CLSCs into a network in order to ensure access to walk-in medical services 365 days per year from 8 a.m. to 10 p.m., in spite of the presence of 2,000 general practitioners and over 250 service centers on the island. Consequently, on certain days and at certain hours, there is a gap in the range of services between emergency services and the CLSC Info-Santé services.

Completing the networking in all our service continuums will be at the heart of the plan to improve services for the 1998-2002 period. We will be emphasizing and intensifying our efforts in this direction, both in areas related to services to the population, as well as those related to administrative and support services.

We feel that the network approach is a solution for the future in the Montreal region. It will ensure improved continuity of services to the population and the best possible use of our resources, while retaining all the richness and diversity of local cultures. However, it is imperative that the members of the network all aim toward common objectives, coordinate their actions, adopt reliable liaison mechanisms and agree to adopt uniform communications specifications and standards.

2.1.3 Public services at the right pace

The Régie régionale reaffirms that it intends to work to maintain and develop access to quality public services in the field of health and social services for the benefit of the entire population.

We are convinced that the best way to avoid setting up two service systems, one for the rich, the other for the poor, is to continue to consolidate and improve the performance of our regional public network by ensuring that the resources and possibilities available to us are put to the best use possible.

The challenge is to ensure the adequate performance of the public network in terms of access to services. Several measures will be proposed in the improvement plan for 1998-2002, in order to consolidate the level of current performance in sectors where it is adequate and significantly improve accessibility in several major sectors, particularly in certain surgeries and ultraspecialized services, specimen collection and laboratory analyses and walk-in medical services.

Since 1995, we have already made significant progress in sectors such as access to specimen collection, by introducing a general walk-in specimen collection system in the region in all the hospitals and, on an experimental basis, in thirteen CLSCs.

We also believe that the improvement plan for 1998-2002 will provide an opportunity to clearly identify our priority objectives in regard to the consolidation and improvement of the performance of the network in terms of access waiting periods. It will also provide an opportunity to clarify our commitments to the population in this regard and to establish as clear as possible an agreement in regard to access waiting periods. The lack of clear benchmarks and objectives is, in

itself, a source of misunderstandings and dissatisfaction.

Another method of improving the performance of the public network is to maximize the combined possibilities offered by the voluntary departure program and the creation of inter-institution networks to reorganize our administrative and support services.

We believe this to be the best direction if we are to consolidate the public nature of the network in these services using the full potential and skills of our personnel to attain the best performance standards in all fields.

The desire to maintain the public nature of the services as we are proposing could go hand-in-hand with a sustained joint effort with the private sector in several fields.

In this regard, we should mention the collaboration of the private sector in residential and long-term care services, in research and in developing Montreal as an international pole for health industries: pharmaceutical research, biotechnologies, information technologies and consultations.

We always promote a pragmatic approach in which we seek partnerships with private enterprise in marketing niches where its contribution could provide a true added value on the economic and social levels, as well as in the quality of services, which must always be universally accessible.

2.1.4 A key element in our mission: teaching and research

There are currently five designated university institutions, in terms of health as well as social activities, while four others are awaiting designation by the Minister. Once the designation process has been completed, the region will have nine (9) designated institutions.

Teaching and research carried out in university institutions often develop outside the main orientations of the Montreal health and social network. They are part of a special continuum supported, in particular, by teaching institutions, research funds and institutions in the health and social service network. In terms of funding, public and private research funds tend to decrease year after year, while the needs of the population, particularly the increase in morbidity and aging, require new approaches and ways of doing things and an increase in specialized resources to deal with them adequately.

The Régie régionale recognizes the importance of the triple vocation of the university institutions in our health and social service network

1. **provision of services**

2. **teaching**

3. **research.**

It is important that teaching and research become more fully integrated in the organization and provision of services in order to promote the vision of health services and social services as part of university training. The Régie régionale has already worked together successfully with the Montreal and McGill universities, particularly in planning medical staffing and in projects concerning university designations. The Régie

Table 4 - INSTITUTIONS DESIGNATED AND AWAITING DESIGNATION

Year	Institutions	Designation
04/1995	Hôpital Sainte-Justine	UHC mother-child
11/1997	Institut de cardiologie de Montréal	Health institute - University institute in the fields of vascular medicine and cardiology
01/1994	CLSC René-Cassin	Social institute - University institute of social gerontology of Quebec
08/1996	Centres jeunesse de Montréal	Social institute - University institute in the field of violence among youth
10/1997	Centre hospitalier Côte-des-Neiges	Social institute - Geriatric institute of Montreal
To come	Centre hospitalier de l'Université de Montréal (CHUM)	Awaiting confirmation for designation as UHC adult
To come	McGill University Health Centre (MUHC)	Awaiting confirmation for designation as UHC adult
To come	Hôpital Maisonneuve-Rosemont	Awaiting confirmation for designation as Affiliated university centre (AUC)
To come	Hôpital du Sacré-cœur de Montréal	Awaiting confirmation for designation as Affiliated university centre (AUC)

intends to extend its participation with the different environments: education, public and private research funds and institutions, in order to establish a dynamic which concretely integrates the changes occurring in the organization of health and social services with the priorities for teaching and research in university environments, while allowing the latter to have an influence on the orientations of our network.

The Régie régionale considers that teaching and research are essential elements in improving services to the population. They encourage the evolution and development of new medical and information technologies which are at the heart of improving the quality and effectiveness of our services. In this regard, the support and funding of these activities are important issues and the Régie régionale intends to use all the levers at its disposal to encourage their growth and maximize the effects throughout the network.

University centres will therefore become fundamentally important in the area of teaching and research, as well as being the sites for development, innovation and evaluation of new technologies. They will serve as the showcase for our achievements on an international level.

In addition to the nine existing university centres in the Montreal region, the Régie régionale will continue its discussions with the Minister concerning university designations in the field of mental health (mental health university institute) and in regard to the CLSCs (university affiliated centre).

By taking a positive position in regard to the importance of consolidating teaching and research, the Régie régionale must establish facilitating conditions so that our designated university centres become desirable and recognized sites.

To achieve this, the Régie régionale must establish criteria especially adapted to the triple vocation of university hospitals for the acquisition and staffing of new medical technologies, for the consolidation of services and support of the latest activities, in particular, ultraspecialized activities such as tertiary cardiology, neurosurgery referred to as quaternary, etc..

Maintaining equipment commensurate with the most recent technology in these centres is therefore a prime concern for the Régie régionale, in order to ensure the success of the shift toward ambulatory care, the quality of diagnostic and therapeutic services and access to technical support centres.

The Régie régionale recommends that a national budget be established for teaching and research, similar to the budget assigned to ultraspecialized services. This envelope should include a portion for services and another for capital funding and the purchase or replacement of the equipment necessary to support the mission of the university centres.

2.2 SPECIFIC ORIENTATIONS TO BE MAINTAINED AND EMPHASIZED

In addition to these four orientations which will influence all our actions over the next three years, our plan to improve services will be based on seven specific orientations.

2.2.1 Services accessible at the right time, for the right person and in the right place

This orientation was at the heart of the plan to reorganize services we initiated in 1995 and we believe that it must be maintained and emphasized.

It responds to fundamental trends on social and economic levels as well as in terms of the effectiveness of health and social services.

It is clear that there is a very strong social trend in the desire to remain at home, in an environment where individuals profit from the greatest degree of independence, with as much control over their personal and social life as possible.

In fact, the ultimate aim of health services and social services set out in the Act reflects this vision of health.

Recourse to institutional services is necessary when the safety and health of the person requires and for as long as required. We must evolve toward the optimum use of these resources and establish resources which are accessible in the home and in the community, both before and after institutional services.

This social trend of preferring to remain in a natural living environment whenever possible and desirable in terms of safety and health, is present in all the service continuums.

It is valid for persons with intellectual impairments, youth and persons suffering from mental health problems.

We must find the right balance between resources accessible in the home and in the community and those accessible in institutions.

In terms of the effectiveness of services and their impact on health and welfare, it is also important that people are able to contact the right network of services at the right time. Still too often, the first point of contact with the network involves very specialized resources (emergency, Youth Protection) when

the situation is already very serious. For example, in the case of breast cancer, it is obvious that the earlier it is detected, the greater the chance of preserving the life, health and welfare of person affected.

Similarly, many people suffering from heart failure frequently find themselves spending long periods in our hospitals, due to a lack of follow-up and adequate and well coordinated primary care.

If we wish our network to operate at the right pace, we must increase our efforts to make use of the five speeds available, at the right time and in a synchronized manner: information, prevention, basic services, crisis and emergency services, specialized treatment and rehabilitation.

A final factor in favor of this orientation: using the right level of care at the right time is more economical for both the network and for the population.

People who have used the Info-Santé service and who do not need to go any farther in the range of services have saved time, energy and money. In the same way, this allows the network to devote its more specialized resources to people in need of this level of care.

Day surgery, when medically indicated, is equally advantageous for both the patient and for the network.

Several of the measures introduced since 1995 were designed with this approach in mind and, in the plan for 1998-2002, we will be proposing several more measures in line with this orientation.

2.2.2 Improved integration of promotion and prevention activities

In the field of prevention and promotion, following a wide public consultation process with all Montreal environments, in 1994 we adopted two orientations that were maintained in the plan to reorganize the network initiated in 1995.

1) To target our actions around four priorities chosen according to their importance for the health and welfare of the population, our capacity to act and the degree to which the environment has been mobilized.
2) To contribute to the development of an effective intersectoral partnership oriented toward action on a local and regional level.

Four regional priorities:

1. ***Infant health and welfare;***
2. ***Optimum development of youth;***
3. ***Violence against women;***
4. ***Breast cancer***

The four regional priorities served as an anchor for consolidating activities with our partners around common targets. A budget of $2.7M was allocated for the performance of these priorities at the starting point in 1995, with reallocations of $13.6M added between 1995 and 1998.

The provincial priorities retained by the Department for 1997-2000 include these four regional priorities. However, the Department has retained five additional priorities concerning:

1. immunizations;
2. HIV-AIDS and sexually transmitted diseases;
3. non-purposive trauma;
4. alcoholism and drug addiction;
5. use of tobacco.

The Department has also introduced a new Quebec strategy to deal with the problem of suicide.

These new elements must be taken into consideration in preparing our regional plan of action for the 1998-2002 period.

The intersectoral partnership on the regional and local level:

To extend the scope of action around the regional priorities and to develop the intersectoral partnership further in order to achieve these ends, the Public Health Department established a regional promotion-prevention advisory committee formed of partners from CLSCs, Centres Jeunesse and community organizations, as well as medical, educational and municipal fields. This committee presided over the first regional prevention-promotion conference in November 1996, which brought some 500 practitioners, researchers and decision-makers together from various sectors of activity to discuss regional priorities for public health within an extended perspective and the improvement of the intersectoral partnerships in the sectors concerned.

Regional orientations in prevention-promotion were identified during this process and adopted by the Régie régionale in June 1997:

Table 5 - REGIONAL ORIENTATIONS

Priority: Infant health and welfare

1. Promotion of cognitive, affective and social development of infants and early support of parents living in poverty.
2. Continuity in prenatal care and services within the scope of the shift toward ambulatory care.
3. Development of food security for families living in poverty.

Priority: Optimal development of youth

4. Socio-economic integration of youth
5. Support for a joint school-community approach
6. Accompaniment of youth experiencing difficulties

Priority: Violence against women

7. Promotion of equality in relations between men and women.
8. Work to prevent isolation and increase a feeling of security among women
9. Awareness-raising, training and support for practitioners in various environments.
10. Prevention of recidivism in violence against women.

Priority: Breast cancer

11. Reduce mortality and morbidity due to breast cancer through a universal regional program.

These orientations are widely shared and represent the development focal points that are most liable to rally regional and local partners in the short term.

In order to establish regional prevention-promotion orientations and to support intersectoral partnership, in June 1997, the Régie régionale committed support funds of $1.4M to joint intersectoral activities.

In our next plan for 1998-2002, we propose maintaining the activities which resulted from the orientations of the plan to reorganize services, *Achieving a new balance*, initiated in 1995 and which is now beginning to bear fruit:

- To achieve the objectives of our four regional priorities by targeting our actions;
- To reinforce intersectoral cooperation focusing on action at the local and regional level.

We propose adding a third orientation:

- To integrate effective measures for prevention and promotion within the service continuums.

One of the characteristics of our plan for 1998-2002 will be to introduce effective prevention measures as early as possible, before crisis and specialized services are required.

Table 6 - INTEGRATION OF PREVENTION AND PROMOTION WITHIN THE SERVICE CONTINUUMS

INFORMATION

•

PROMOTION-PREVENTION

•

SUPPORT

•

BASIC SERVICES

•

CRISIS OR EMERGENCY INTERVENTION, ACUTE-CARE

•

SPECIALIZED OR ULTRASPECIALIZED TREATMENT

•

REHABILITATION / SOCIAL REINTEGRATION

This means tending toward an approach which enables persons at risk within the population to be reached at the right time, by effective primary prevention interventions before the appearance of a disease and by secondary prevention involving early identification and early, effective and efficient treatment at the right level of care according to the development continuum of certain well targeted diseases.

2.2.3 Targeting instead of scattering

In determining our regional priorities in health and social services in 1994, as well as in choosing the measures for our reorganization plan, *Achieving a new balance*, we have always preferred an approach which targets our measures rather than scattering our developments and reductions in expenditures throughout the activities of the regional network.

We feel that now, more than ever, it is essential to retain this orientation in our plan for 1998-2002, since our possibilities of mobilizing more resources toward our priority objectives are reduced.

Setting priorities means making choices. For us, this means carefully choosing our priorities according to their importance

for the health of the population and our capacity to act in order to achieve the improvements desired.

Scattering resources among too many different measures is ineffective and is often the result of a compromise between the wishes of all interest groups.

We prefer to concentrate our efforts on a limited number of targets that we can be confident of attaining. The challenge will be to choose the right priorities for improvement for the years 1998-2002, knowing that we cannot increase everything, improve everything in all sectors.

2.2.4 Benchmarking with the best practices

Another orientation that we are going to stress and generalize in order to improve the performance of our regional network is benchmarking with the best practices.

In Montreal, we wish to attain the current quality and efficiency standards of the best services in Quebec, Canada and elsewhere in the world, in a comparable context and with comparable resources.

Attaining the best standards demands constant work, patience and creativity. We must objectively assess performance, compare it to the best in each field, correctly diagnose the elements to be improved, change our ways of doing things. Benchmarking does not mean comparing in order to glorify or blame, but to learn and to improve by adapting the best practices possible to the context of each environment.

With the improvement of information systems, the increasing number of statistical tools and case studies available now facilitate self assessment and benchmarking in comparison to the best results and best practices observed. However, ultimately, it is the desire to examine the facts, to make the right diagnosis and to act in consequence, which makes all the difference in this field.

If we wish to improve, it is more useful to look beyond averages and work to ensure that everyone evolves toward the best results, by correctly diagnosing the causes of the differences in performance.

For example, when we say the average waiting period for access to the CLSC Info-Santé line is 3.5 minutes. This masks the fact that, on one hand, there are significant variations between CLSCs and, on the other hand, between different times of the week. Seeking solutions to these differences is an important tool for improvement.

In the follow-up of the project, *Achieving a new balance*, we used benchmarking in different related sectors, particularly in the performance of hospitals in regard to the emergency department and length of stays, and in the efficiency of residential and long-term care centres.

We intend to use this approach in a universal manner in all the continuums of services to the population and in analyzing the performance of administrative and support services, as always, within the perspective of identifying ways to improve.

2.2.5 Continuous quality improvement for all

Since 1994, the Régie régionale has initiated a process designed to orient the regional network toward the adoption of an integrated continuous service quality improvement process. Since then several steps have been accomplished.

First, we have taken on measurement tools and an analysis model which enable the follow-up and assessment of the attainment of the principal objectives of the plan to reorganize the network.

For this purpose, we developed a trend chart, grouping 18 indicators used to follow developments in the network's performance and to make comparisons to performances recorded prior to the reorganization.

The Régie régionale also adopted a regional service concept specifying the essential expectations of the population to which all the institutions must respond as closely as possible in their manner of providing services on the relational, professional and organizational levels.

In May 1994 and in May 1997, we assessed user satisfaction in regard to the twelve dimensions of our regional service concept.

Also, in 1995-1996, we accelerated implementation of integrated continuous improvement user satisfaction programs in our network of institutions. Over twenty institutions, representing all categories, are participating as pilot sites for implementation of the regional service concept.

An integrated assessment was made of the links between hospitals, CLSCs and physicians for the provision of post-operative and post-hospital home-care. This integrated assessment involved the implementation of the linkage mechanisms, patient satisfaction, quality of services provided and the satisfaction of the practitioners.

Another assessment concerned the impact of the reorganization on access to services and on the state of health perceived by the population in comparison with the data from the "Santé Québec" survey.

Lastly, we developed measurement tools that are better adapted to assessing efficiency in various categories of institutions and services: hospitals, psychiatric hospitals, residential and long-term care centres. Similar work has been commenced in regard to the CLSCs.

These initiatives, introduced over the past three years, have provided markers enabling our improvement plan for 1998-2002 to advance toward an integrated and generalized quality improvement approach for all.

OFFERING QUALITY FOR ALL MEANS, AMONG OTHERS:

- Working in all the service continuums to improve quality, in a continuous manner, in regard to satisfaction of the population, efficiency and the impact on health and welfare.
- Having an integrated strategy for skill development and mobilization of the personnel, keeping in mind that:
  - the quality of services depend, to a great extent, on the quality of the relations between the personnel and the users and the way in which professional expertise is delivered;
  - the population's two most important expectations are to be able to deal with people who are competent and to be treated with respect.
- Adopting a new integrated table of indicators covering all aspects of quality.
- Making an integrated quality assessment of the results obtained by several important measures in the improvement plan for 1998-2002:
  - efficiency: waiting period for access to services, volume, costs;
  - user satisfaction;
  - impact on health: morbidity rate, mortality rate, rehospitalization rate.
- Implementing integrated accountability throughout the network.
- Passing from pilot projects to generalized continuous improvement programs.

1.2.6 Recognition of the community and intersectoral partnership

While recognizing the importance of living conditions as determining factors, the Régie régionale firmly believes that the citizens are also, individually and collectively, the first line responsible for their own health and welfare. It recognizes that the voluntary or volunteer commitment of a group toward finding means to respond to new or unsatisfied needs or proposing different approaches are eminently expressed by the activities of community organizations.

In 1994, the Régie régionale took on the community development vision retained by the Conseil régional de développement de l'île de Montréal:

> *"Community development is a development model, a way of doing things. It is founded on citizens taking responsibility for their own needs and solutions in all sectors of human activity. It calls on the capacity of local communities to take responsibility for orienting their own development".*

This vision must be put into practice by recognizing and pursuing the financial consolidation of community groups as partners of the health and social service network and not as one of its components, as are the institutions.

This recognition requires that the following principles are respected:

- recognition of the independence, expertise and skill of community organizations;
- adherence to a global approach in regard to avoiding fragmentation of the problems experienced by the population;
- equity of funding according to the needs of the population served, taking the financial resources available into account;
- simple, effective and transparent management;
- coherence of interventions involving community organizations.

In the project, *Achieving a new balance* for 1995-1998, in spite of its objective to reduce expenditures by $190M, the Régie régionale increased subsidies to community organizations by $14.9M, from $35M to close to $50M per year, representing an increase of 42%.

The Régie régionale also adopted an integrated funding policy

for association activities within the community which, in Montreal, includes over 400 subsidized organizations in the health and social service sector. This policy is designed to facilitate association activities on a multisectoral basis for issues affecting all the organizations, as well as on a sectoral basis according to specific themes.

Finally, we adopted a very transparent process for allocating subsidies and ensuring consultations with sectoral groups and the intersectoral group representing the community environment.

Our plans for the future include adopting terms of recognition for community organizations in which the principles and orientations guiding our relations with them will be formally identified.

In the plan to improve services from 1998-2002, we have also chosen to emphasize intersectoral participation on both the regional as well as the local levels. This increased cooperation, focusing on action will involve our partners in the community environment as well as those in the sectors of education, municipalities, justice, public safety, cultural communities and immigration, and social and economic development, according to common and freely shared objectives that they will choose.

2.2.7 Respect of the linguistic and ethnocultural characteristics of the population

The Island of Montreal presents a rich and diversified mosaic: 24% of the population in the region are immigrants compared to 9% in the Province. Close to six out of ten residents are French-speaking; English-speaking people represent 20% of the population and other language groups count for 22%.

The respect of this ethnocultural and linguistic diversity is an essential orientation for the Régie régionale which must always seek the right balance between the diverse expectations of the population and the many rights at play within the context of resources available and laws and policies in force.

By virtue of the Charte de la langue française, it is clear that every person is entitled to receive services in French in all institutions. In addition, the Charte assigns the right to be able to work in French. However, it provides that an employer can require the knowledge of a language other than French if the position necessitates.

On the other hand, every English-speaking person is entitled to receive health and social services in English, taking into account the resources available and within the measures provided by the access program. This access program is the tool by which the Régie régionale ensures the respect of this right.

The institution is responsible for managing the delicate balance between these rights at the local level. For example, a designated institution must ensure that its services are accessible in French. It must then also determine the number of positions which require the knowledge of a language other than French in relation to its obligations toward the clientele. The dosage must be established locally by the institutions. If they believe that their rights have been violated, both users and workers have recourse. For example, a French-speaking person who did not receive services in French can make a complaint to the Office de la langue française, as can a worker who thinks that the employer has identified too many positions as requiring the knowledge of a language other than French.

In the same way, a person who did not receive services in the designated language in an institution designated as being able and obliged to render services in a language other than French may submit a complaint

It is this delicate balance that we have sought to maintain in the access program for services in English, which has been in force in the region since 1989. Since this program was introduced, the number of complaints by users and workers has been very low. This is even more remarkable in view of the complexity of the laws and the environment in which we live.

At the Department's request, in view of the reorganization which has taken place in the health and social service sector since 1995 and following a consultation within the environment, the Régie régionale initiated a revision of its access program. In December 1996, following a unanimous decision made by the Board of Directors, the Régie régionale forwarded its recommendations to the Minister of Health and Social Services.

Our fundamental orientation is to find the right balance between the various needs and rights at play, taking into account the nature and quantity of our resources. In the Montreal region this is no small challenge, but it can be met if we approach it with serenity, mutual respect, and the desire to preserve a consensus in the community.

In order to adapt services to the ethnocultural characteristics of the population of the region, in 1990, the Régie régionale adopted an access plan which was revised in March 1997.

The Régie régionale has integrated accessibility for ethnocultural communities in all its activities since 1994,

whether they involve implementing regional priorities for prevention and promotion, or the project to reorganize services initiated in 1995. The regional service concept developed in 1994 to assess clientele satisfaction also takes the expectations of people from ethnocultural communities into account.

Our plan of action, revised in 1997, includes four special orientations:

1. The introduction of programs and measures which provide approaches adapted to the particular needs of clienteles on the cultural level.
2. The reduction of barriers and limits to accessibility by supporting intercultural training, information and interpretation, particularly by maintaining and improving the regional bank of interpreters.
3. The development of a partnership with ethnocultural community organizations.
4. The development of a better knowledge of the ethnocultural communities and promotion of research focusing on improving practices.

In the field of health and social services, the culture of the people served is an important element that must be considered.

In the plan to consolidate and improve services from 1998-2002, this concern will be at the heart of several measures proposed, particularly in regard to services for the elderly and for youth, promotion and prevention and services present in all the service continuums.

2.3 INCORPORATING PREVENTIVE MANAGEMENT IN THE PROVISION OF SERVICES

The desire of the Régie régionale to ensure continuous improvement of the impact of health and social services on the health of the population (effectiveness) as well as on the cost of services dispensed (efficiency) has led to proposals for new orientations and approaches to consolidate the network transformation process.

In order to maintain the population's health for as long as possible and to provide pertinent services for people with health or social problems, since it is clear that the necessary resources available are going to remain limited, the Régie régionale wishes to explore a more preventive approach in the management of service provision in the network. This preventive management of services consists of adapting services to the various population groups according to their specific needs. **It provides for action before the risks, problems or their consequences arise, whenever possible.**

This approach involves considering three separate population sub-groups (table 7 below). The first is the group which perceives its health as being excellent or very good; it has no or few risk factors or vulnerabilities, clinical manifestations or diseases. This group is rarely incapacitated and generally uses only the basic health and social services. This group represents roughly half the population of Montreal and tends to be found in the group who are under 45 years of age and who have a higher level of education and income.

A second population group perceives its health as good and

Table 7 - NEED AND USE INDICATORS ACCORDING TO THE DECLARED STATE OF HEALTH MONTREAL-CENTRE - 1993

	Declared state of health		
	Excellent or very good health (51.7 %)	Good health (37.4 %)	Average or poor health (10.9 %)
Consumption of at least one medication during the preceding 2 days	48.4 %	57.3 %	75.5 %
Consultation with a health professional during the preceding two weeks	22.0 %	27.9 %	42.0 %
High psychological distress indicator	20.2 %	30.3 %	48.6 %
Persons limited in their activities	1.7 %	5.5 %	43.6 %

Source : Sortie spéciale, Santé Québec, Enquête sociale et de santé 1992-1993.

includes slightly more than one-third of the population of Montreal. The people in this group rarely suffer from problems requiring specialized or sophisticated services, but frequently present one or more risk factors or vulnerabilities (tobacco use, excess weight, alcohol abuse, family risk of heart disease, etc.) or certain health problems. This group is found mainly among 45-64 year-olds and typically has an average level of education and a lower-middle income. Their needs lead them to use first and second-line services, through consultations in private practices or hospital out-patient clinics.

A final group, approximately one Montrealer in ten, has one or more health problems or active social problems. This third group is the one which uses the greatest portion of the network's resources. The people in this group have recourse to more intensive medical and social interventions, which require a high level of professional or technological expertise and which are generally the most expensive. The elderly, 65 years and over, make up the main portion of this group and close to half of them have disabilities.

In an approach which seeks to prevent these phenomena and in view of the fact that resources are limited, the Régie régionale seeks:

1. To increase the number of people who remain in good health;

2. To ensure that, as quickly and actively as possible, persons in group 2, who present vulnerability or risk factors, or an early problem (e.g.: hypertension, adjustment or behavioral disorders, diabetes, etc.) receive services adapted to their condition in their natural living environment, in order to maintain their health and welfare for as long as possible and to reduce the need for recourse to more costly services;

3. To provide persons who are ill or incapacitated, the most effective services in the most pertinent and efficient manner possible according to their needs. To the extent that the services provided early are appropriate, preventive management should also keep the number of people belonging to this group as well as the needs for more weighty and costly services, as low as possible.

This risk management approach is not necessarily new. What is new is that the Régie régionale wishes to test a populational and preventive management approach to health problems, in collaboration with clinical and university environments as well as with groups of patients.

For example, let us consider diabetes. We know that a large portion of people who suffer from diabetes only learn of their disease when complications set in. However, if the diagnosis is made earlier, complications could be avoided. This means that blindness and lower limb amputations among diabetics can be avoided in 1997 if an active follow-up and the patient's participation in his/her treatment are strongly encouraged and supported. Such an approach to diabetes would prevent complications or, at the very least, delay their appearance thereby providing a significant improvement in the person's health.

Another example: We know that the earlier breast cancer is discovered in a woman, the greater the chances of successful treatment. This is the basic idea behind the screening program which the Régie régionale is about to initiate as part of the provincial screening program recently announced by the Minister. However, and this is another dimension of the populational preventive approach, in order for early screening for breast cancer to achieve results, it must be organized and followed-up. Measures must be taken to ensure women use it, health professionals must provide information, quality tests must be accessible, diagnostic delays and treatment must be kept to a minimum, personnel must be well trained, the technology available must be up-to-date and, finally, we must ensure that the targeted results are achieved. This universal management approach is not customary for the system. We hope to include it in our physical health approach for the chronically ill, such as cardio-vascular patients and their risk factors, diabetes patients, as well as in breast cancer.

We also hope to include it in all the other service continuums, particularly in social adjustment. For example, we know that early stimulation programs for infants from disadvantaged environments can involve costs of around $50,000 per child, if they extend from the prenatal period until kindergarten. However, without such programs, the equivalent costs for society could reach $300,000 per child if we take into account the costs related to corrective interventions, social assistance, social services, repression of crime and social reintegration.

Finally, to ensure that the large majority of the population remain in the first group for as long as possible and, in view of the impact of the social and economic determining factors on the health and welfare of the population, the Régie régionale wishes to work together with the municipal, school and business communities in order to improve conditions and living environments which are often associated with health and welfare problems.

To summarize, the Régie régionale wishes to work with its partners in testing a preventive approach for managing the

health of the population. The objectives are to ensure that the greatest number of people possible remain healthy for as long as possible and that those who are at risk or have problems receive the services they need in order to prevent or delay complications and incapacities. Finally, as the Plan clearly demonstrates, the Régie régional intends to continue to work at increasing the efficiency of services and improving the linkage mechanisms between service providers.

We believe this approach will enable the professionals in the health and social service network to have a greater impact on the health and welfare of the population.

3

CONSOLIDATION AND IMPROVEMENT OF SERVICES: A RENEWED PLAN OF ACTION FOR 1998-2002

The proposal submitted for consultation provides a clear outline of the plan to be implemented over the next four years to consolidate the balance between the needs of the population, the organization of services and the resources available and to ensure that significant improvements are made in certain priority sectors.

In keeping with our general and specific orientations, the measures proposed involve six service continuums:

1 Physical health services
2 Services for the elderly experiencing a loss of autonomy
3 Services for persons with physical impairments
4 Mental health services
5 Services for persons with intellectual impairments
6 Social adjustment services
5 levels :
6.1 Services for children, youth, young adults and their parents
6.2 Services related to violence against women
6.3 Services related to alcoholism and drug addiction
6.4 Services for the homeless
6.5 Services related to AIDS

The results of the implementation of the 40 measures introduced in the various service continuums over the past two years will serve as the starting point for the plan to improve services for 1998-2002.

For each of the six service continuums, we will present the principal points raised during the consultation, as well as the measures suggested, objectives and results to be targeted and the conditions necessary for their performance.

3.1 CONTINUUM OF PHYSICAL HEALTH SERVICES

In continuity with the service organization plan for 1995-1998, we wish to intensify certain measures in order to improve the structural organization and efficiency of the network while ensuring its consolidation. To this end, our objective is a continuum of accessible, continuous and integrated services.

This service continuum is founded on the identification and implementation of linkage mechanisms between the various service providers and intervention levels. These linkage mechanisms serve to maximize continuity of services, coordinated within a network and to minimize compartmentalization between intervention levels.

SOLUTIONS FOR THE FUTURE IN PHYSICAL HEALTH

Promotion of health and prevention

3.1.1 Target and integrate promotion of health and prevention interventions

First-line medical services

3.1.2 Improve first-line medical services in physical and mental health

Pertinent and high quality general, specialized and ultraspecialized services in hospitals

3.1.3 Maintain access to general and specialized services in general and specialized care hospitals
3.1.4 Improve the organization of ultraspecialized services
3.1.5 Improve access to ambulatory care and services in each general and specialized care hospital
3.1.6 Implement a permanent solution to congestion in emergency departments
3.1.7 Maintain 6,062 acute physical care beds corresponding to 2.2 beds/1,000 inhabitants
3.1.8 Introduce a system to assess the pertinence of hospitalizations and stays
3.1.9 Improve the use of resources in surgery and specific plans of action in neurosurgery, orthopedics and ophthalmology →

3.1.10 Improve access to radio-oncology
3.1.11 Improve access to tertiary cardiology services and adult and pediatric cardiac surgery
3.1.12 Establish a development fund to aid access to specialized and ultraspecialized services
3.1.13 Improve access to diagnostic radiological examinations

Post-hospital and post-operative services in local communities

3.1.14 Improve post-operative and post-hospital home-care and consolidate linkage mechanisms

Palliative care in institutions and in homes

3.1.15 Improve palliative care

Laboratories

3.1.16 Improve the accessibility and efficiency of the laboratory network

Principal points raised during the consultation:

In our partners view, we must be very prudent, the care system is fragile and should be consolidated before we go any farther in the transformation process.

- The current number of beds should be maintained, mainly because of the needs of the population and current impacts of demandd on emergency departments and waiting lists for surgery;
- The mission, role and position of the UHCs, UACs, general and specialized care hospitals and small and medium-sized hospitals need to be more clearly defined;
- The introduction of ambulatory care centres proposed (5) was unanimously approved, except that the other hospitals indicated that their services must continue to be transformed, which means that their premises must be adapted in order for them to be efficient;
- The concept of care for sub-acute infections was not perceived by the institutions as being a profitable measure;
- The introduction of a tool to evaluate the pertinence of hospitalizations and the length of stays was approved by the large majority of the practitioners who suggested using existing tools;
- Concerns were expressed in regard to grouping laboratories, which would have negative effects on the efficiency and quality of services as well as on medical coverage for all clientele of general and specialized care hospitals;
- Decentralization of walk-in specimen collection services in the CLSCs was considered by all the practitioners as being a good way to improve access to services for the population;
- The proposal to improve ultraspecialized services was generally approved;
- The CHU Sainte-Justine mère-enfant et the CUSM (Montréal pour enfants) expressed their willingness to participate in establishing means to reinforce the Montreal pediatric network, to ensure effective, efficient and high quality tertiary and quaternary services;
- The participants agreed on the need for a development fund for specialized and ultraspecialized services, but concern was expressed in regard to the source of this fund;
- The improvement of post-hospital care must be continued;
- Palliative-care practitioners approved of the proposal to improve palliative care and indicated their interest in participating, without being restricted to a single model for the region;
- The problem of congestion in emergency rooms has several causes and is systemic; the situation must be examined before, during and after;
- A 10% decrease of long-term patients in general and specialized care hospitals would enable better use to be made of acute-care beds.

PROMOTION OF HEALTH AND PREVENTION

3.1.1 Target and integrate promotion of health and prevention interventions

Several improvement objectives could be considered for the next three years; however, in view of our wish to target actions and retain conditions which will have a favorable impact in the short and medium term, we are proposing a limited number of objectives for improvement in the prevention / promotion sector. These choices are based on Departmental requests concerning provincial priorities for public health, as well as regional needs in physical health identified as part of the first phase of the plan. True to the preventive management approach that we have adopted for the consolidation plan, we are therefore proposing developments which will allow actions to be taken before these priority problems arise. These actions can be supported from the current level of resources by reorienting and adapting the services offered by providers to the different levels of intervention in the continuum.

■ Increase the struggle against breast cancer:

If we are to pursue the orientations of the Health and Welfare Policy and the regional priority involving the struggle against breast cancer, implementation of the Quebec breast cancer screening program is an essential measure.

The objective of the screening program is to reduce the rate of mortality caused by breast cancer by at least 25% by the year 2006, compared to the rate in 1996 among women between the ages of 50 and 69. To attain this objective we must aim at achieving a participation rate of the target clientele of at least 70% and must offer services which meet high quality standards. Screening must also be part of a global strategy in the struggle against breast cancer.

Implementation of this program is well suited to the plan for 1998-2002, since it involves reorganizing services for screening and investigating breast cancer and designating a limited number of specialized centres which, from now on, will offer the services required.

Means of action:

- Implement and assess the Quebec breast cancer screening program in the region and ensure that a continuum of services (screening, diagnosis, treatment, psychosocial support) is established in order to reduce mortality and morbidity related to breast cancer.
- Inform and raise the awareness of women in all environments, as well as practitioners in the health and community network, in regard to problems related to breast cancer and screening methods in order to maximize the rate of participation of the target clientele and encourage the judicious use of resources.
- Ensure that quality standards are achieved in the continuum of services offered.

■ Improve cardio-vascular health:

Considering the extent of the problems related to heart failure, myocardial infarction and cerebrovascular accidents in Montreal-Centre, the Régie proposes a routine approach which considers the continuum of these diseases ranging from health determinants to morbidity and mortality and which focuses on the results to health throughout this continuum. In particular, there is a significant potential for advances to be made in hospital practices during admissions for heart failure (treatment, length of stay, counseling) and in sharing of expertise between the first-line physicians and medical specialists to improve follow-ups and avoid the need for readmission of this type of clientele.
The plan of action will stress the prevention of risk factors (hypertension, hyperlipidemia, obesity, diabetes, etc.), promote heart health (improving dietary habits, control of tobacco use, increase in physical activity), and maximize health care and services.

Means of action:

- Introduce and assess an integrated global populational management program for cardiac insufficiency involving the clients, CLSC practitioners, family physicians, family medicine units, medical specialists, practitioners in the schools and social workers, partners in pharmaceutical companies, foundations and medical associations.
- Optimize hospital practice at the time of admission for cardiac insufficiency (treatment, length of stay, counseling) and share expertise between the first-line physicians and medical specialists in order to provide a follow-up and avoid readmission of this type of clientele.

■ Prevent and control communicable diseases:

Several problems associated with communicable diseases must be given special attention in the current context of the ambulatory shift in services. The new methods of organizing services actually raise the risk that infections which, until now, were limited to hospitals could begin to develop at home and eventually spread to the community. The emergence of new infectious and antibiotic-resistant strains is a growing source of concern. There are also frequent omissions and delays in reporting certifiable diseases, as well as a lack of effectiveness in the control measures required, in comparison to North-American standards. The use of available vaccines continues to be suboptimal, even though they are preventive interventions which involve net savings for the health system. Improving the linkage between practitioners and a more active participation by the various clinical environments are, more than ever, essential for the protection of the health of the population against infectious agents.

Means of action:
The institutions and medical establishment must take responsibility for their participation in achieving the following objectives:

- Rate of basic vaccination coverage of 85% among infants (current rate estimated at 75%);
- Rate of vaccination coverage against measles of 85% on entering kindergarten (current rate observed is 60%);
- Rate of vaccination coverage against hepatitis B of:
  90% among 4th grade students (current rate estimated at 85%);
  80% among young drop-outs (current rate presumed to be very low);
  80% among gay men (current rate estimated at less than 50%);
- Rate of complete vaccination coverage against hepatitis A

of 60% among gay men (current rate estimated at less than 45%);
- Rate of vaccination coverage against influenza among target groups of 60% in open environments (current rate estimated at less than 45%) and 80% in closed environments (current rate estimated at 73%);
- Complete reporting of certifiable diseases by clinic and laboratory technicians and participation in the medically required interventions for post-exposure, particularly in regard to tuberculosis and HIV;
- Judicious use of antibiotics and prevention of resistance to them.

This measure must be performed using the resources currently assigned to the network. Attaining these objectives will require increasing vigilance on the part of first-line professionals and institutions. The Direction de la santé publique, for its part, will continue its work to increase awareness among clienteles and provide feedback to the service providers in regard to the effectiveness of their interventions.

■ **Prevent disabilities caused by backaches:**

Backache constitutes the primary cause of disability in the adult population. This condition is responsible for a considerable number of requests for first-line services, specialized orthopedic services, physiatry, neurosurgery and rehabilitation services.

There are guidelines concerning the management of backache designed for persons suffering from backaches and their physicians, the application of which could reduce half of the disabilities related to backache, whether they be physical, psychosocial or occupational.

Means of action:
Establish a regional program to promote back health and coordinate care for people suffering from backache, in order to support the attending physician in his case management. Participation in the program would be voluntary. It includes a standardized approach for clinical examination and management of the condition. The program is led and supported by an information resource and intervention support centre for back health at the Direction de la santé publique.

FIRST-LINE MEDICAL SERVICES

3.1.2 Improve first-line medical services in physical and mental health

3.1.2.1 Integrated organization model for first-line medical services

The Régie régionale de Montréal-Centre believes that, together with the institutions and general practitioners working in the CLSCs, medical clinics, private practices, residential, long-term care and rehabilitation centres, we must redefine the entire organization of basic medical services performed in general practice in its territory.

It is time that we progress from acting as a group of institutions and professionals to creating and operating a true network of care and services. In so doing, we must concentrate on the health objectives, accessibility, quality and continuity of the services required to respond to the needs of the population of the Montreal-Centre region.

In order to achieve its objectives for quality and efficiency in improving the provision of first-line medical services, the Régie régional is initiating the organization of a global and integrated network of general medical services in its territory.

The Régie régionale favors a family medicine approach. This case management and regular follow-up of persons at the first-line level facilitates the establishment of a relationship between the physician and the patient which allows a more detailed understanding of the patient and permits the physician and patient to identify the problems, while taking the family and social environment into account, thereby enabling the best solutions to be found. This can often mean that recourse to second-level services for more advanced investigations and specialized treatments can be avoided when they are not required by the patient's state of health.

By moving services closer to the community, the shift toward ambulatory care emphasizes the importance of the continuity of care provided by the attending physician. There are two important concepts concerning continuity of care: the first is the regular follow-up of a person at the first-line level by a physician who takes charge of all the individual's health problems and the second concerns the information which must be forwarded when the patient is referred or transferred to another professional or to an institution. These concepts structure the duties and obligations of the attending physician toward his/her patient, particularly during a referral.

A) Guiding principles :

- Accountability of all general practitioners for the provision of medical services;
- The family medicine approach: the concept of case management and follow-up;
- Continuity of care and services: at all levels and between levels;
- Referrals and the concept of the attending physician: obligations and responsibilities to the referred patient;
- Integration of preventive activities and education in current medical practice;
- The free flow of communications and the free flow of referrals.

B) Organizational principles:

- The CLSCs, medical clinics and private practices: gates of entry and providers of first-line medical services. To make the most efficient use of available human and financial resources, the Régie régionale proposes:
  - Consolidation of medical consultation services with and without an appointment in all sub-regions and recognition of sites (CLSCs - medical clinics - private practices, depending on the resources available) to provide walk-in medical services, seven days a week from 8 a.m. to 10 p.m., 365 days per year.
  - Consolidation of multidisciplinary-type medical services in the CLSCs (home-care, mental health, palliative care and other specific programs) with a global approach, working together with physicians from medical clinics and private practices.
- The creation of the Département régionale de médecine générale (regional department of general practice).

3.1.2.2 The integrated network of first-line medical services

The network must involve all the general practitioners in the territory of the Régie régionale de Montréal-Centre who offer first-line medical services (mental health and physical health), wherever they practice: residential and long-term care centres, rehabilitation centres, CLSCs, medical clinics, medical polyclinics, or private practices.

The mission of this network, which includes the entire population of the territory of the Régie régionale, will be to organize and provide a complete range of continuous, acute and long-term health care and services, including prevention, diagnosis, treatment, rehabilitation, social reintegration, palliative care and mental health. In providing medical consultation services in the home and palliative care, including AIDS and mental health, within the normal scope of his/her medical practice, the general practitioner must ensure continuity of care for his/her patients, with easy access to specialized expertise in these fields assured. This must apply to all forms of these services: medical consultations with an appointment, walk-in medical consultations, medical consultations in the home and specific medical programs, no matter where the services are provided (CLSCs, private practices, medical clinics and polyclinics, in homes, residential and long-term care centres, or rehabilitation centres). This general care network must also be linked with the second and third-line specialized care networks.

The creation of the Département régional de médecine générale (Regional department of general practice) has been proposed as the means to establish and implement the integrated network of first-line medical services.

3.1.2.3 Territorial division

In implementing an integrated network of first-line medical services respect will be paid to the citizens' natural habits and movements in seeking consultations, as well as to organizations which have already established efficient links. Montreal-Centre's context is one in which there will be a free flow of both citizens and physicians between sub-regions. By enabling case management and follow-up to be performed at the right time, this could have the effect of reducing the number of people reporting to emergency departments.

We propose that the territory of Montreal-Centre be divided into five sub-regions: East, West, South-west, Centre and North. Each of these sub-regions will be responsible for ensuring its population is provided with global and uniform, general first-line medical services within the specific programs retained.

3.1.2.4 Specific measures related to the integrated network

- Improve access to medical consultation services with an appointment and within a reasonable waiting period (0-4 weeks) so that all citizens who make a request can have access to them.
- Improve the accessibility and efficiency of walk-in medical consultation services, particularly during evenings, on weekends and holidays from 8 a.m. to 10 p.m..
- Improve access to medical consultation services in the home for persons experiencing a loss of autonomy:
  - Ensure that the service is available within the required period: less than 48 hours or less than two weeks, depending on the need.
  - Establish an on-call, medical home-service network in each of the sub-regions. This service will be accessible to persons experiencing a loss of autonomy who have a CLSC home-care service plan.
  - Establish a medical transition team in each of the five sub-regions for patients who have complex health

problems, such as cardiac insufficiency or severe respiratory insufficiency.
  - Establish teams of physicians to provide palliative care in each of the five sub-regions.
- Improve access to medical consultation services in residential and long-term care centres, rehabilitation hospitals and centres.
  - Ensure adequate medical staffing to provide services and support a medical on-call service within these institutions.
- Improve the continuity of services between physicians, institutions:
  - Establish a bank of available general practitioners to ensure access to an attending physician.
  - As soon as a patient is admitted to a hospital, initiate the procedure to identify an attending physician who will provide the post-hospital follow-up.
  - Ensure flexible communications and referral methods between all partners in the integrated network. Systematize and simplify the transmission of medical information concerning a patient during a referral or a transfer.
- Make sure the population is well informed in regard to services available and the hours they may be accessed.
- Integrate preventive activities and education in first-line medical practice and, with the participation of the Direction de la santé publique, develop practical tools for this purpose.
- Systematize the Régie régionale's follow-up, by using general and specific indicators.

PERTINENT AND HIGH QUALITY GENERAL, SPECIALIZED AND ULTRASPECIALIZED SERVICES IN HOSPITALS

3.1.3 Maintain access to general and specialized services in general and specialized care hospitals

The general and specialized care hospitals in the Montreal-Centre region provide acute-care physical services to a pool of 2.7 million people. Their mission is to offer diagnostic services and general and specialized medical care. No matter what their size, the contribution of each hospital is of prime importance in the provision of services to the population. The general and specialized care hospitals which do not have a university mission, serve a pool of over 700,000 people, representing one quarter of the regional service pool. The distribution of hospitals in the territory enables wider clinical as well as geographic access. The population's expectations and the Régie régionale's objectives seek to ensure the provision of high quality diagnostic and medical services. To this end, each hospital offers hospitalization and ambulatory services, working together with the other partners in the physical health continuum.

An integral part of the Montreal-Centre scene, several health institutions have developed close links with the universities in Montreal. The region has three university hospital centres, university institutes as well as centres affiliated with universities. In addition to their primary care mission, these hospitals also have missions for teaching in the field of health science, research and evaluation of health technologies. Their own missions are also extended: they offer specialized or ultraspecialized services in one or several medical disciplines.

SERVICES FOR ADULTS

3.1.4 Improve the organization of ultraspecialized services

With the goal of respecting standards of practice in ultraspecialized services, ensuring efficiency and coordination and facilitating access to the population we must serve on the metropolitan and provincial levels, the Régie régionale recommends the following organization: (see table 8 at right)

This proposal is designed to promote the organization of these ultraspecialized services in six poles: Centre hospitalier de l'Université de Montréal, McGill University Health Centre, Institut de cardiologie de Montréal, Hôpital Maisonneuve-Rosemont, Hôpital du Sacré-Coeur and the Jewish General Hospital - Sir Mortimer B. Davis.

These hospitals are in a good position to be able to adequately meet the needs of both our metropolitan and provincial service pools. They have the combination of expertise and critical mass required to meet practical standards in the ultraspecialized services they render. University hospitals play a predominant role in providing a range of ultraspecialized services. In addition, university affiliated centres and institutes work in complementarity with the UHCs while maintaining one or more points of excellence of their own.

Maintaining six major poles appears to be the best solution for the future in order to facilitate access to the population that we must serve, no matter where they come from, and to ensure our resources are used to their fullest while respecting quality standards.

Table 8 - ORGANIZATION AND DISTRIBUTION OF ULTRASPECIALIZED SERVICES IN HOSPITALS FOR ADULTS

PROGRAMS	CHUM	MUHC	Inst. Card. de Montréal	Maisonneuve-Rosemont	Sacré-Coeur	Jewish General
Neurosurgery	PM	PM		P	P	P
Traumatology/Tertiary centre		PM*			PM*	
Ophtalmology	P	P		PM	P	P
Radio-oncology	P	P		P		P
Oncology	P	P		P	P	P
Cardiology / Medecine	PM	PM	PM	P	P	P
Cardiac surgery	PM	PM	PM		P	P
Cardiac defibrillators	P*	P*	PM*		P*	
Neonatology[1]	P	PM		P		P

Table 9 - CURRENT PORTRAIT OF THE TRANSPLANT PROGRAM[2]

Bone marrow transplant		P*		PM* homologous graph	P*	A (1996)
Kidney	P*	P*		P*		
Hearth	A	P*	P*			
Hearth-lungs	A	P*				
Lungs	P*					
Liver	P*	P*				
Pancreas	P*	A				
Pancreas - kidney	P*	A				

Legend:
P = ultraspecialized program
M = major centre
* = departmental designation
A = undesignated activities

PEDIATRIC SERVICES

The Régie régionale proposes introducing four joint regional pediatric care and service programs in certain medical subspecialties or any other solution which would resolve the problems identified below. The programs involved cover cardiac surgery, tertiary cardiology, neurosurgery and organ transplantation.

The populations in the Montreal-Centre region and the rest of Quebec are fortunate to have access to high quality pediatric services in two children's hospitals. Each of these hospitals, Hôpital Saint-Justine and the Montreal Children's Hospital, is affiliated with a famous university. Over the years, the latest developments in pediatric medicine, referred to as tertiary and quaternary, have evolved in a parallel manner in each of these institutions, linked with their respective university and teaching and research programs at the Université de Montréal and McGill University.

Since the number of children in Quebec who need health care and services in the latest fields is limited, the coexistence of all the programs in each of these hospitals creates difficulties. This duplication of activities creates the most problems in the following specialties: cardiac surgery, tertiary cardiology, neurosurgery and organ transplantation.

The principal problems identified affect all phases of the mission of the pediatric hospitals: care to the population, teaching and research. Very few children require care related to the latest medical and professional expertise, which means that few physicians and professionals are required, resulting in small teams. The region therefore maintains two series of small, highly expert teams who compete for clientele, organizational resources (physicians, professionals and technology), residents and research funds.

Unfortunately, the provision of services to these children is affected by this lack of complementarity. Few physicians mean it is more difficult to provide medical coverage at all times and has a detrimental effect on access for the clientele. The

[1] Hôpital Sainte-Justine, PM should be added to these centres.

[2] Transplantations : work in progress following the recommendations of the Gélinaux Report.

departure or illness of one single physician places the program in danger. The low volumes of clientele do not enable hospitals to have access to the critical mass necessary to maintain and develop expertise and improve the quality of these services. For all these reasons, we consider action in this area to be a priority.

To resolve these problems, the Régie régionale proposes introducing four joint regional pediatric care and service programs in certain medical subspecialties. The programs involved cover cardiac surgery, tertiary cardiology, neurosurgery and organ transplantation.

The concept of a joint regional care and service program requires pooling the service organization elements enabling services to be provided to the clientele. For a given regional program, we will have:

- sharing of expertise between professionals associated with the case management of this particular clientele;
- a single waiting list providing access to services according to priorities determined by clinical staff;
- services accessible for both English-speaking as well as French-speaking clients ;
- a regional budget identified according to specialty.

A joint regional care program will also be attached to the inter-university teaching and research programs in this subspecialty. A regional program would be conducive to the survival and development of various aspects of pediatric subspecialties in Montreal. In comparison to other Canadian hospitals, the two pediatric hospitals would be more competitive in regard to access to care, teaching and research resources.

Conditions for performance:

- The hospitals' formal commitment, by resolution of their boards of directors, to establish the joint programs or any other solution which will resolve the problems identified;
- The rapid introduction of mechanisms enabling the model retained to be implemented.

Performance schedule : November 1998.

3.1.5 Improve access to ambulatory care and services in each general and specialized care hospital

Ambulatory hospital services are substitutes for the investigations and care provided to a hospitalized person through the provision of services dispensed in less than 24 hours. The hospital offers access to a pool of expertise or technical support which is not found elsewhere.

Over the years, hospitals have served their clientele by adapting their methods of practice. This has led to a gradual transfer of care toward ambulatory services. This trend is increasing; the volume of hospitalizations is decreasing in favor of ambulatory services.

Pressure is placed on hospital infrastructures by the increasing volume of clientele which will be augmented further by new categories of ambulatory patients. Hospitals are increasingly receiving clients with complex medical problems on an out-patient basis. This clientele will need ambulatory care services which require more time for preparation, transport and nursing supervision, as well as more technical personnel.

The increasing volume of the clientele, its complexity and the intensification of ambulatory care may become major causes for operational and logistic ineffectiveness. Each general and specialized care hospital must rethink its program of ambulatory care in order to adjust to the changes in administrative and professional practices in ambulatory care and to the changes in clientele.

Renovation of premises, functional access to technical support centres and particularly, the organization, operations and management of ambulatory care will become priorities in all the general and specialized care hospitals.

One of the solutions to the problems in hospital emergency departments will be to facilitate investigations through access to technical support and specialized consultations on an ambulatory basis.

In view of this situation, the Régie régionale is continuing its work to establish ambulatory care centres in hospitals. The functional and technical program to modernize the Lakeshore General Hospital and to organize ambulatory services has been submitted. The Régie régionale and the Department are currently examining possibilities for financing the project.

The planning phase for the ambulatory centres in the Hôpital du Sacré-Coeur and the Hôpital Maisonneuve-Rosemont is

progressing well. Teams from both hospitals have each prepared a functional and technical program as well as a preconcept for construction proposals for the ambulatory centres.

Discussions between the hospitals, the Régie and the Department are underway. We expect to establish an extremely efficient organization of services and respond to the needs identified using the resources available. We expect an increase in the volume of visits and treatments on an ambulatory basis from 20 to 30% for each of these ambulatory centres. Each ambulatory centre will provide services involving over 1,000 visits and treatments per day. Only carefully planned activity logistics, coupled with the suitable premises will enable the targeted users to be served.

At this stage, we are convinced that for both organizations, the ambulatory service centre is the solution for putting an end to fragmented services, out-of date and overcrowded premises, inappropriate access for patients and a lack of operational efficiency. Grouping activities together according to specialized service functions and their proximity will enable flexibility and efficiency for the user and the staff.

As for the ambulatory service centres in university hospitals (CHUM and MUHC), planning has been initiated as part of clinical services. The reorganization of the clinical services of several pavilions in a single hospital involves important changes in the provision of services to the clientele. The physical arrangement of premises required to serve clientele on an ambulatory basis is part of the total planning of the UHCs. For the Régie régionale, ambulatory centres in university hospitals are an important priority.

3.1.4 Implement a permanent solution to congestion in emergency departments

Problems related to congestion in emergency rooms are numerous, complex and have many origins. Several practitioners, involved and/or called on in the operation of the emergency rooms attended the hearings to present their point of view. It is becoming increasingly clear that this is a generalized problem which involves the entire health network.

We agree with the Commission médicale régionale, in supporting the theory that solutions to the problem of too many patients on stretchers in emergency rooms are to be found before the patient arrives at the emergency as often as during the time spent there, during hospitalization in the institution and on the patient's return to the community.

It is clear that the number of people who report to the emergency room must be limited and steps taken so that the network operates in such a way that there is rapid access to the services required (specialized medical consultations, laboratories and medical imagery) outside the emergency room.

We therefore note that the measures introduced must be network solutions and must be integrated within a service continuum which responds rapidly at the right moment and in the right place to the needs of the diverse clienteles.

For this reason we propose the following focus and means:

- Medical services accessible within the community, including access to diagnostic services such as laboratories, medical imaging examinations and specialized medical consultations, without requiring recourse to the emergency department;
- Each hospital must work together with the community it serves in order :
  - to improve the knowledge of clienteles who report to the emergency department;
  - to establish an operating method which permits access to the services required by its clientele without requiring recourse to the emergency department, such as a personalized telephone reception and appointment system which enables the needs of the clientele to be met (specialized clinics for diabetes, respiratory insufficiency, cardiac insufficiency or others) within the delay required by their condition;
  - to make its technology and equipment available to attending physicians from the CLSCs and private practices, such as blocks of time reserved to enable rapid access to a diagnostic examination through direct, effective means and within the time required;
  - Establish effective ways of transmitting information to the attending physicians including computer systems.

Objective targeted:
To ensure that all the emergency departments on the Island of Montreal attain the standards established by the Groupe tactique d'intervention (G.T.I.) and operate without congestion.

Results targeted:
To attain the following results in all hospitals:

- No stay in the emergency department shall exceed 24 hours;
- Respect the periods set for decisions:
- less than 8 hours for patients who are not admitted;
- less than 12 hours for patients admitted to the hospital.

MEASURES TO AVOID REQUIRING RECOURSE TO AN EMERGENCY DEPARTMENT:

- Improve access to first-line medical services between 8 a.m. and 10 p.m., 7 days per week;
- Promote the family medicine approach;
- Ensure access to laboratory services, medical imaging and specialized consultations for the clientele of physicians in the community;
- Make efficient use of programs for target clienteles, such as day centres for diabetics, regional home-care service for pulmonary patients, specialized clinics to follow-up pulmonary and cardiac patients with a referral from the attending physician;
- Introduce a sub-regional on-call system in residential and long-term care centres directly linked to the hospitals in order to reduce the number of visits to the emergency department made by patients in these centres who could be stabilized in their institution.
- For clientele in a crisis situation, make psychiatric community resources available when hospitalization can be avoided.

MEASURES TO ENSURE SMOOTH OPERATION OF EMERGENCY ROOMS:

- Obligatorily implement the SIURGE information system in all emergency rooms: within one year in emergency rooms with problems and within two years in all emergency rooms;
- Have a sufficient number of physicians to respond to emergency clientele within the targeted periods;
- Establish a medical on-call system when overcrowding occurs in the emergency;
- Increase the role and responsibilities of general practitioners in the emergency;
- Increase access to laboratories and medical imaging for emergency clientele in order to attain targeted waiting periods;
- Ensure the availability of consultant specialists in order to attain the targeted waiting periods;
- Adapt the linkage mechanisms between the hospitals and CLSCs for clientele in emergency rooms and ensure that case management is provided in the home within 24 hours following a request made during a discharge from the emergency room;
- Ensure that CLSCs take over the case management of clientele experiencing a loss of autonomy screened in an emergency room if they are not hospitalized;
- Make social emergency beds available in residential and long-term care centres, 24 hours per day, 7 days per week;
- Establish a triage system and a team assigned to triage in the emergency room. Protocols must also be established so that the nurse can commence the investigation of patients without delay, according to the rules established by the professional corporations involved.

EFFICIENCY MEASURES IN HOSPITALS:

- Ensure internal resources are managed efficiently (see the other measures proposed such as the average length of stay, day surgery, etc.);
- Obligatorily implement a tool to evaluate the pertinence of hospitalizations and the lengths of stay;
- Ensure the follow-up and case management of elderly persons during their stay in hospital;
- Distribute beds according to a generally effective organization plan and provide for a seasonal variation in beds available by specialty depending on the needs of the clientele.

MEASURES IN THE COMMUNITY:

- Use concrete means to maximize the linkage between hospital-CLSC-attending physician;
- Eliminate waiting periods for rehabilitation services;
- Ensure CLSCs take over the case management of clientele experiencing a loss of autonomy screened in an emergency room;
- Ensure there are a sufficient number of beds to avoid overcrowding in acute-care beds by elderly clientele who require placement, and thereby ensure the most efficient use of acute-care beds.

REGIONAL MEASURES:

- Introduce the ambulatory care centres as planned (Lakeshore, Maisonneuve-Rosemont, Sacré-Coeur, CHUM, MUHC);
- Balance the ambulance transport load between the outlying hospitals and those in the downtown area, working jointly with the Corporation d'Urgences-Santé. Institutions which receive a higher number of ambulances will be dealt with as a priority;
- Hospitals which have submitted a plan of measures designed to prevent congestion in the emergency room should apply their plans in full and the CHUM shall submit its revised plan of measures in order to end →

congestion in its emergency room;
- The hospitals must ensure they attain the results targeted and maintain them;
- Reduce the number of long-term beds in hospitals to 10% in order to maximize the use of acute-care beds. Each institution shall implement all the measures to avoid any overcrowding above the number of beds on the permit;
- With the levels concerned, examine the hindrances to access to services, such as remuneration of radiologists;
- Investments planned must be performed in order to decrease waiting lists and avoid the inappropriate use of emergency rooms.

3.1.7 Maintain 6,062 acute physical care beds corresponding to 2.2 beds/1,000 inhabitants

All hospitals shall maintain an availability rate of 2.2 beds per 1,000 inhabitants for acute physical care with an occupation rate of 90%. Maintaining 6,062 beds represents practically all the beds used in 1996-1997. We propose consolidating services while maintaining a sufficient maneuvering margin to adjust to periodic variations in clientele, particularly those in the hospital emergency departments in January and February.

This volume of 6,062 beds is distributed between the hospitals in the region. Maintaining a number of beds determined regionally for each hospital puts an end to decisions on closing beds at the local level. Any request to lower the capacity of a hospital shall be subject to an examination and specific approval by the Régie régionale with a view to maintaining access to services. The hospital shall be obliged to demonstrate that the following parameters have been attained:
- establishment of a system to evaluate the pertinence of admissions and stays;
- elimination of delays caused by the hospital;
- an average length of stay comparable to the best lengths of stay for similar cases;
- a volume of clientele treated comparable or higher to the volume in 1996-1997;
- attainment of 100% of the potential for day surgery;
- attainment of 85% of anticipated surgeries performed on the day of admission;
- attainment of a volume of user hours-presence in the surgery department comparable to or higher than the results in 1996-1997, as well as additional objectives which will be forwarded by the Régie régionale, if applicable.

The objective of 2.2 beds per 1,000 inhabitants will be obtained by a combination of reducing admission rates and lengths of hospital stays by 7.5%. In spite of maintaining a volume of beds equal to the current usage, this decrease of 7.5% will be necessary in view of the slight increase in the service pool and the aging of the population, since the rate of admission per 1,000 inhabitants increases proportionally with age after the age of 65 years.

The reduction in the admissions rate is possible through the elimination of avoidable or non-pertinent admissions in acute-care, by identifying these admissions and referring the user to appropriate resources, such as ambulatory services. In order to reduce the length of hospital stays, inappropriate days must be identified and substitute resources made available, providing services which respond to needs. Attaining this objective depends on the availability of several types of resources and conditions facilitating access to them.

The distribution of beds between the hospitals in the region is detailed in the following table. The institutions' permits will be issued taking this base into account.

Elements which are the responsibility of the hospitals:
- The use of a system to assess the pertinence of stays in order to make an objective identification of the portions of hospital stays for persons who need resources other than acute-care beds;
- Management of hospital stays to ensure the best possible use is made of resources and to eliminate avoidable delays;
- The attainment of 100% of the potential for day surgery for clientele identified as suitable;
- Surgery on the day of admission with the introduction of pre-operative investigation of the clientele on an ambulatory basis;
- Ambulatory care centres will be organized to deal with heavy volumes of clientele by means of multidisciplinary care teams and working in continuity with the community network.

Follow-up of results according to personalized objectives for each hospital:
The Régie régionale wishes to attain the objectives identified and to maintain services to the population. To this end, we will determine parameters with personalized objectives for each hospital.

Other conditions for performance depend on the services being organized in continuity with those provided by the hospitals (see the measures in the continuums concerned):
- Rapid access to intensive functional rehabilitation resources;
- Access to resources for the elderly in their homes, in

Table 10 - **DISTRIBUTION OF ACUTE PHYSICAL CARE, NEONATOLOGY AND LONG-TERM CARE IN RESIDENTIAL AND LONG-TERM CARE CENTRES 1998 TO THE YEAR 2002**

INSTITUTIONS & PAVILIONS	Acute physical care beds	Neonatology beds	Total	Long-term care beds
Pavillon Notre-Dame	420		420	45
Pavillon Hôtel-Dieu de Montréal	387		387	35
Pavillon Saint-Luc	433	20	453	45
CHUM	**1,240**	**20**	**1,260**	**125**
Montreal Children Hospital	144	28	172	0
Montreal General Hospital	382		382	38
Royal Victoria Hospital[3]	425	27	452	43
Hôpital Neurologique de Montréal	96		96	0
MUHC	**1,047**	**55**	**1,102**	**81**
Hôpital Sainte-Justine[4]	346	57	403	30
Hôpital Maisonneuve-Rosemont	549	20	569	108
Hôpital du Sacré-Coeur de Montréal	439		439	25
Jewish General Sir Mortimer B. Davis Hospital	489	34	523	49
Institut de Cardiologie de Montréal	151		151	0
Lakeshore General Hospital	210		210	15
Hôpital Santa Cabrini	358		358	36
CH Fleury	123		123	15
Hôpital Jean-Talon	186		186	25
CH de Lachine	118		118	15
CH de St-Mary	222		222	22
Shriners Hospital	40		40	0
Pavillon Verdun	308		308	11
Pavillon Lasalle	50		50	25
C.H. Angrignon	**358**		**358**	**36**
REGION	**5,876**	**186**	**6,062**	**552**

[3] Includes the 44 beds of the "Pavillon thoracique".

[4] The 30 long-term care beds in Hôpital Sainte-Justine are not included in the info-admissions system.

intermediate-type resources and in residential and long-term care institutions;

- Access to post-hospital and post-operative services provided by the CLSC. These services are designed for pediatric and adult clientele, requiring medical, surgical or obstetrical services in acute physical care hospitals;
- Introduction and reorganization of a service organization model for palliative care.

Implement a system to assess the pertinence of hospitalizations and stays

In cooperation with its partners, the Régie régionale is continuing work to implement a system to assess the pertinence of acute-care. The hospitals will use an assessment tool to verify the pertinence of the patients' presence in acute-care units. Among others, this involves identifying patients who could receive the appropriate care in another environment, such as the home, or units providing rehabilitation care, or long-term care.

Assessment studies of hospitalizations in several Canadian provinces (Manitoba[5], Saskatchewan[6], Ontario[7], British Columbia[8]) indicated that a large percentage of hospitalized

[5] DeCoster et al, "Inappropriate hospital use by patients receiving care for medical conditions: targeting utilization review", Canadian Medical Association Journal, oct 1997, 889-895.

[6] Health Services Utilization and Research Commission (HSURC), Barriers to Community Care, Saskatoon, nov 1994.

[7] Joint Policy and Planning Commitee (JPPC), Non-Acute Utilization Project (Adult), april 1997.

[8] Centre for Health Services and Policy Research, Acute Medical Beds: How Are They Used in British Columbia, april 1997.

patients did not need acute-care and, consequently, a significant number of days-presence were used inappropriately. A number of studies indicated that only 47% of the patients still required acute-care after 7 days of hospitalization.

On the other hand, reducing acute-care services without introducing review and use-management mechanisms, does not enable inappropriate services to be eliminated, nor does it reduce the risks associated with long stays in the hospital, such as infections, rehabilitation problems, etc.

The Régie régionale therefore recommends establishing a system to assess the pertinence of stays to identify inappropriate days in acute-care and their causes. Using clear criteria, each hospital will revise a portion of its patients' records during their hospitalization. This will permit an objective determination of whether the care required by the patient's condition needs to be provided in hospital or could be provided elsewhere. The tool must also reveal unnecessary delays in the patient's case management, such as delays for diagnostic tests or consultations.

Results targeted:
Each hospital shall make a concomitant review of a portion of its admissions and stays, using recognized protocols and criteria. This review will be performed in fields selected according to the medical activities of the hospital and will enable inappropriate stays in acute-care to be recognized at the time of hospitalization.

It will also be used to identify structural and organizational elements responsible for these non-pertinent stays so that the corrective measures required can be clearly defined.

Schedule for performance:
Each hospital will be asked to implement a system to assess pertinence of hospital stays by October 1998.

3.1.9 Improve the use of resources in surgery and specific plans of action in neurosurgery, orthopedics and ophthalmology

The Régie régionale is implementing a series of measures in order to ensure the best possible use of hospital resources for surgery. The appropriate use of beds and operating rooms according to the needs of clienteles will be part of the measures to be implemented, with the hospitals' and surgeons' participation.

In the transformation plan for 1995-1998, measures were implemented to maintain operating capacities in spite of the fact that hospital closings resulted in the closing of nine surgery departments. To this end, since 1996-1997, over $4M has been paid to the hospitals in order to increase the number of operating hours in the surgery departments.

The Régie still maintains its objective of achieving the full potential in day surgery. The introduction of ambulatory care centres is one of the means proposed and is already being implemented. We observe a constant increase in the volume of surgeries transferred to day surgery, but have not yet achieved 100% of the potential. In 1995-1996, 87% of the potential was attained, but this means that more than 10,000 surgical interventions were carried out during a hospital stay even though the patients had met all the medical criteria for day surgery.

In neurosurgery, certain problems concerning access to surgery were raised in regard to persons suffering from brain tumors. The Régie régional intends to improve this situation with the hospitals involved. We also wish to facilitate access to neuro-radiological interventions in the university hospital centres (UHC). This technology, introduced recently, requires medical expertise that is already concentrated in the two UHCs treating adult clientele. Depending on the patient's needs, access to this national service offers the neurosurgeon the choice between a neuroradiological intervention and invasive surgery.

In orthopedics, as at September 1997, over 1,200 people were on the waiting list for surgery requiring a total prosthesis in hospitals in the Montreal region. Of this number, 620 people, or 55%, have been waiting for at least six months.

In the field of eye surgery, the number of people waiting and the waiting period have increased by 25% in one year. A large portion of these 8,500 people require a cataract operation. In view of the aging of the population, developments in the technology for this surgery and the decrease in its associated risks, the number of people who are potential candidates for this type of surgery can only increase. The current organization of services has not been able to respond adequately to the increase in clientele and this has resulted in longer waiting periods.

DESCRIPTION OF THE SOLUTION :

- Establish a minimum production level for surgery departments in each hospital, based on previous production and additional resources already allocated;
- Together with the hospitals concerned, identify alternate solutions to using the surgery department for interventions which do not require the department's →

technical support and professional expertise;
- Taking into account an evaluation of our technology and practices, as well as those used elsewhere in Canada and in other countries where progress has been made, examine the potential for additional increases in day-surgery and set new result objectives if applicable;
- Keep each hospital informed in regard to the level to which it has achieved the potential for day surgery, as well as the list of interventions and case volume;
- Link the performance assessment of the hospital with incentives to achieve the potential for day surgery;
- Relaunch the program for admission to day surgery for anticipated surgery and advance scheduling of dates for surgery;
- Prepare a plan of action to combat long waits for surgery in the following surgical specialties: neurosurgery, orthopedics and ophthalmology.

Specific plans of action for priority surgical specialties:
In the surgical specialties of neurosurgery, orthopedics and ophthalmology, certain interventions are targeted due to the waiting lists. Specific plans of action will be prepared for these surgical interventions in order to improve access to them. These interventions are, in **neurosurgery**: brain tumors, neuroradiological interventions and implantation of rachidian neurostimulators; in **orthopedics**: total hip and knee prostheses, and in **ophthalmology**: surgery involving cataracts and the retina.

The plans of action involve two phases:
1) The introduction of measures enabling services to be provided promptly to clientele who have been waiting for surgery for 6 months or more, or according to the waiting time-limit set by the surgeons;
2) The introduction of measures to rectify the situation for the other people on the waiting list and for new cases which will be added to the list for the targeted interventions.

Depending on the specialty, plans of action will be developed with the participation of the surgeons in each specialty and hospitals' representatives. The Régie régionale proposes the following:
- Complete the collection of information on waiting lists according to the type of surgical procedure targeted, and according to hospital;
- Collate the information on the resources and surgical priorities allocated to these procedures in the hospitals;
- Determine the proportion of urgent interventions and elective cases for these interventions in each hospital;
- Together with the surgeons and as required, identify priority clientele according to the impacts on mortality and morbidity and draw up criteria enabling priority levels to be determined
- Establish a waiting list time-limit for targeted interventions;
- Analyze the data and make a diagnosis of clientele in each hospital according to the criteria on priority clientele;
- With the hospital, identify the causes for unacceptable waiting periods;
- With the hospital concerned, identify solutions enabling the situation to be corrected when waiting periods are unacceptable according to the criteria determined;
- Examine whether the solutions are within the jurisdiction of the region and hospitals and if so, implement them. It is possible that the solutions identified oblige the region to make choices, taking the overall resources available into account. If solutions depend on levels other than the region, take the necessary steps to correct the problem;
- On a regular basis, collate information on waiting periods according to the criteria determined until the problem is resolved.

A functional system for managing waiting lists in each hospital is essential and a prerequisite in order for the Régie to be able to implement a regional follow-up system on the waiting periods for targeted interventions:
- Identify the information necessary for monitoring;
- Support hospitals in implementing the system to measure waiting periods;
- Disseminate information to the population

Results targeted in surgery:
- Maintain an operating capacity of 195,000 patient interventions (274,000 user-hours-presence);
- A waiting time-limit determined by clinical technicians for the targeted surgical procedures;
- 100% of the potential for day surgery;
- 85% of elective surgery carried out on the day of admission;
- Each hospital must introduce an integrated management system for their waiting lists according to the risks for the clientele as well as the resources available.

Conditions for performance:
The involvement of the surgeons and hospitals is essential to the pursuit of these objectives. Each hospital must introduce a management system for its surgical waiting list, taking into account the priorities of the clientele and the time-limits for waiting periods according to resources available.

A development fund is proposed to enable these activities to be performed:

- for the purchase of operating room equipment in order to facilitate endoscopic surgery in day surgery from the regional budget for specialized equipment;
- to adjust resources enabling targeted surgical procedures to be increased.

If necessary, methods of remuneration for physicians must be adjusted to facilitate effectiveness of targeted objectives.

3.1.10 Improve access to radio-oncology

Current situation:
In 1996-1997, $651,000 was granted to Hôpital Maisonneuve-Rosemont and $450,000 to Hôpital Notre-Dame in order to complete the development initiated in radio-oncology. The effect on the waiting list was evident in 1996-1997.

Action required:

- Ensure a priority follow-up of waiting lists for breast cancer, cancer of the cervix, lymphoma, otolaryngology for pediatric clientele and treatments required as palliative care.

3.1.11 Improve access to tertiary cardiology and adult and pediatric cardiac surgery

A) Plan of action in cardiac surgery
Following actions taken since June 1997, the waiting list has been reduced from 500 patients to 377 as at March 31, 1998, representing a 25% decrease.

Objective:
To reduce the waiting list to zero and then to ensure that patients receive surgery within no more than one month and that all urgent cases are treated as a priority within 24 hours and all semi-urgent cases within 24 to 72 hours.

1. Action to be continued:
Introduce software to improve waiting list management, with the following objectives:

- Standardize case priority assignment;
- Keep track of the waiting list situation both locally and regionally;
- Improve the assignment of clientele priorities according to clinical condition;
- Verify the accessibility of services to clienteles in other regions;
- Keep track of waiting periods on a regional or local basis

Schedule: June 1998.

2. Actions to be taken:

- Identify efficiency measures in each hospital, if applicable, including grouping services together in a single site in the UHCs;
- Evaluate the capacity of each institution to increase the number of surgeries performed per week;
- Make non-recurring investments according to the capacity of the hospitals to produce the targeted objectives and establish a corresponding timetable to completely eliminate the current waiting list;
- ensure that the number of surgeries performed each week allows access to be maintained within a one-month period;
- Adjust the provision of services according to our objective.

B) Plan or action in tertiary cardiology
In order to ensure access to services, we wish to work with the medical specialists to develop plans of action according to the following stages:

- Collect the information necessary to monitor angioplasty interventions, pacemaker implantations and hemodynamics;
- Use a common language to determine waiting periods for hemodynamics, angioplasty and pacemaker implantations;
- Determine the proportion of urgent interventions and elective cases in each hospital;
- Monitor expectations according to the patient's location: in hospitals, in hospitals in outlying regions or in the home;
- Identify needs according to priority clienteles;
- With each hospital, identify the causes of unacceptable waiting periods and find solutions to correct them;
- Examine whether the solutions proposed are within the jurisdiction of the hospitals and the region and, if so, implement them according to the resources available.

A functional system for managing waiting lists in each hospital is essential and a prerequisite in order for the Régie to be able to implement a regional follow-up system on the waiting periods for targeted interventions:

3.1.12 Establish a development fund to aid access to specialized and ultraspecialized services

In continuity with the measures proposed, we must release the required resources to maintain the balance between the offer and demand for services for which we have unavoidable commitments to our users (renal dialysis, transplantations):

- to ensure the continuous adaptation of services to the increase in volume of specific needs;
- to enable improvements in access to services that we would like to achieve in certain priority sectors.

The funds allocated to the various programs are designed to:

- improve **general access to surgery** by increasing surgical production to the desired level;
- decrease waiting periods for surgery for brain tumors in **neurosurgery**; decrease the waiting list for installation of neurostimulators to control pain and facilitate the introduction of neuroradiology interventions in the UHCs;
- reduce the waiting periods for surgery involving hip and knee prostheses in **orthopedics**;
- decrease the number of patients on the waiting list and reduce the waiting period for cataract surgery in **ophthalmology**;
- make up for shortfalls in **tertiary cardiology** by the non-reutilization of catheters, the increase in requests for implantation of coronary defibrillators and stents and in order to decrease waiting lists in adult cardiac surgery to prevent programmable cases of pediatric surgery from being cancelled. The funds assigned to the catheters will be used to make up for the shortfall of $6.5M;
- compensate for the increase in volumes of **transplantations** for hepatic, pulmonary and bone marrow transplants. Adequate funding must be provided to respond to the increase in demand in this sector which depends on organ donations;
- consolidate **renal dialysis** services and respond to the increase in volume which is around 8 to 10% each year on a regional basis. We must also find a way to consolidate services in the western portion of the island by 1998-1999.

We estimate the funds necessary from 1999 to 2002 at $58,530,600, of which $12,964,600 is non-recurring and $45,566,000 is recurring. (See the following table).

In view of the anticipated increase of needs in these sectors, by 1999-2000 an amount of $23.2M must be planned for, of which $13M will be assigned to reduce waiting lists and $10.2M to meet the increase in volume. It is essential that the waiting lists be brought to an acceptable level in tertiary cardiology, cardiac surgery, orthopedics, neurosurgery and ophthalmology.

For the years 2000-2001 and 2001-2002, amounts of $16.7M and $18.7M per year will be necessary to consolidate services

Table 11 - DEVELOPMENT FUND FOR ACCESS TO SPECIALIZED AND ULTRASPECIALIZED SERVICES

Measure	Annual estimate							
	Non-recurring development			Recurring development				Total
Priority programs	1998-99	1999-2000	Total	1998-99	1999-200	2000-2001	2001-2002	1998 to 2002
A) Tertiary cardiology								
Catheters					$1,300,000	$2,600,000	$2,600,000	$6,500,000
Defibrillators		$638,000	$638,000		$252,400	$504,800	$504,800	$1,262,000
Stents		$2,009,600	$2,009,600		$576,000	$1,152,000	$1,152,000	$2,880,000
Adult cardiac surgery		$1,477,000	$1,477,000		$782,000	$1,564,000	$1,564,000	$3,910,000
Pediatric cardiac surgery		$370,000	$370,000		$260,000	$520,000	$520,000	$1,300,000
Sub-total		**$4,494,600**	**$4,494,600**		**$3,170,400**	**$6,340,800**	**$6,340,800**	**$15,852,000**
B) Transplantation					$444,600	$889,200	$889,200	$2,223,000
C) Renal dialysis					$584,400	$1,168,800	$1,168,800	$2,922,000
D) General access to surgerye					$700,000	$1,400,000	$1,400 000	$3,500,000
E) Neurosurgery		$110,000	$110,000		$600,000	$600,000	$777,000	$1,977,000
F) Ophthalmology		$860,000	$860,000		$200,000	$400,000	$400,000	$1,000,000
G) Orthopedics		$6,500,000	$6,500,000		$360,000	$720,000	$720,000	$1,800,000
H) Endoscopic instruments		$1,000,000	$1,000,000					
I) Other needs					$818,400	$1,636,800	$4,636,800	$7,092,000
1) Lakeshore ambulatory centre								
2) Diagnostic radiology and others								
J) Radio-oncology					$1,200,000	$2,400,000	$2,400,000	$6,000,000
K) MRI scanning					$600,000	$600,000		$1,200,000
L) Consolidation of the traumatology program					$1,500,000	$500,000		$2,000,000
Sub-total		**$8,470,000**	**$8,470,000**		**$7,007,400**	**$10,314,800**	**$12,391,800**	**$29,714,000**
GRAND TOTAL		**$12,964,600**	**$12,964,600**		**$10,177,800**	**$16,655,600**	**$18,732,600**	**$45,566,000**

and meet the needs of the population.

Since services in tertiary cardiology, neurosurgery and transplantation are provincial in scope, it will therefore be absolutely necessary that the provincial budget contributes to funding the improvements targeted in these sectors including those designed to completely eliminate the waiting list in cardiac surgery.

3.1.13 Improve access to diagnostic radiological examinations

The various problems reported in regard to the organization of radiology services which have impacts on accessibility and waiting periods at the diagnostic level indicate that we must make a generalized analysis of the situation:

- Long waiting lists for out-patient clientele for certain examinations (e.g.: ultrasonography, CAT scans);
- The difficulty in accessing these services experienced by patients in the emergency department as well as hospitalized patients;
- The limited number of examinations carried out by radiologists at certain periods of the year due to constraints related to remuneration (closed budget and ceilings).

An analysis of the situation is even more urgent in view of the shift toward ambulatory care in which objectives are set to treat a wider clientele on an out-patient basis and to decrease hospital stays, as well as the need to eliminate congestion in emergency departments. Radiology is a support specialty for all medical practice so it is important to ensure its organization and operation have a positive effect on the process of assessing and treating patients in the community, in emergency rooms and in hospitals.

It is also important to correctly assess the impact of spiraling technological developments and the extent of the related investments.

Objectives targeted:

- Improve access and decrease waiting periods and waiting lists for diagnostic radiology examinations by maximizing the available resources and making better use of designated examinations;
- Offer public services within acceptable periods of time according to the user's condition.

Conditions for performance:

- Involvement of the players concerned:
  General and specialized hospitals
  Private clinics
  Radiologists
  Professional organizations
  Others, if applicable

Results expected:

- Development and analysis of the current portrait of service provision;
- Identification of actions to be implemented in order to eliminate the problem of waiting lists and waiting periods;
- Improved efficiency by maximizing the use of resources in place;
- Priority clientele established according to their clinical condition;
- An increase in medical imagery resources, if required, including equipment.

POST-HOSPITAL AND POST-OPERATIVE SERVICES IN LOCAL COMMUNITIES

3.1.14 Improve post-operative and post-hospital home-care and consolidate linkage mechanisms

Measures proposed:

- Increase CLSC budgets for post-operative and post-hospital care by $5.3M.

In order to consolidate and increase post-hospital services in the home provided by the CLSCs, it is essential to continue to invest in this area. Targeted clienteles are all clientele who need services following their discharge from general and specialized care or rehabilitation hospitals, including palliative care and perinatology care. In addition, these services must be able to be used in such a way as to avoid the need for recourse to hospitals, that is directly in the home or from the emergency department.

- Pursue, complete and consolidate the linkage mechanisms connecting the general and specialized care and rehabilitation hospitals, CLSCs and attending physicians in order to ensure that all users concerned receive continuity of care and services in the short and long-term, including the provision of pharmaceutical care and services.

Activities to be performed:

- Revise and adjust the reference model to include all post-hospitalized clientele in order to eliminate multiplication of linkage mechanisms according to the various service continuums;
- Relaunch the reference model and ensure that the

establishment of linkage mechanisms remains a priority for institutions and that these mechanisms are the focal point in continuity of services to the population;
- Follow up the recent assessment made by the study and assessment department and prepare a plan of action which divides responsibilities between the local, sub-regional and regional levels;
- Design a purchasing model for special equipment and supplies which is rapid, profitable and effective and which enables the rationalization of costs related to purchasing, maintenance and transport;
- Develop a follow-up mechanism for the implementation of the single form for multi-clientele and inter-institution referrals launched on October 1, 1997 and a revision process after one year of use. Ensure the availability of a continued training program for practitioners which must be developed jointly with the institutions, UHCs - general and specialized hospitals - CLSCs to maintain and improve service quality;
- Ensure that the hospitals and CLSCs set up a continued training program for their staff;
- Pursue activities related to the collection, analysis and feedback of the results obtained from follow-up indicators;
- Participate in the organization of medical services and ensure that the principles and responsibilities of the attending physician provided in the linkage mechanisms are taken into account.

PALLIATIVE CARE IN INSTITUTIONS AND HOMES

3.1.13 Improve palliative care

Since 1973, the knowledge and means to intervene in order to reduce or eliminate the pain and physical symptoms and psychosocial and spiritual suffering involved in the terminal phase of a disease have evolved a great deal. However, we note that the care and services provided to users in the terminal stage are often absent in the main focuses of services in the Prevention/promotion continuum and curative rehabilitation, integration and social adjustment services. It should also be noted that these services tend to spread slowly in our region, in an irregular manner, without being properly coordinated. More specifically, in regard to this type of care, we note the following:
- Disparity in the knowledge of how to control pain and symptoms, with the result that too many users continue to suffer needlessly;
- The use of acute-care beds and the large number of people who die in institutions;
- Diversity in service provision approaches;
- The lack of an organization model which would enable continuous high quality services to be offered, accessible 24 hours/day, 7 days/week to individuals who wish to die t home and in various institutional environments;
- The ethical and legal problems facing practitioners;
- Deficiencies in the response of psychosocial services;
- Insufficient training of practitioners and volunteers.

Objectives targeted:
In order to correct the above-mentioned problems, a regional care and service model for users in the terminal phase must be developed. This model must be based on existing experience in the network and enable the following general objectives to be attained:
- Complete and continuous interdisciplinary care and services for users and their relatives available in various institutional, intermediate or community resource environments according to the user's wishes;
- Services dispensed in a coordinated and complementary manner between the different partners in the service continuum, to enable the user to be treated in the right location and at the right time;
- The expertise required to alleviate or eliminate pain, physical symptoms and psychosocial and spiritual suffering related to the terminal phase of life must be disseminated to all practitioners working with this clientele.

Results targeted:
- Obtain a true portrait of the palliative services available today;
- Define and introduce a care and service organization and provision model for all users in the terminal phase, based on a partnership between the various players in the network. This model must be based on the "single window" concept developed for elderly clientele experiencing a loss of autonomy and must include:
  - ambulatory teams (for each sub region) available 24 hours per day;
  - sufficient interdisciplinary home-care services offered by CLSC teams, supported in complementarity by the Association d'Entraide Ville-Marie and Victoria Order Nurses;
  - community services offering assistance and support, accompaniment and respite-emergency care;
  - the capacity to receive clientele in intermediate resources or residential and long-term care centres and in temporary shelter programs;
  - a palliative-care service in hospitals offering an oncology program, which includes an ambulatory-care service, an interdisciplinary consultation-liaison team and an acute-care unit. In this model, the services of the CHUM and

MUHC will be responsible for research and training.

- Make a training program available for the staff, including the medical establishment.
- Develop an information system to monitor the development and efficiency of the resources established.

Conditions for performance:

- A decision made by the board of directors and the administration of each hospital with an oncology department to establish the continuum of services for patients in the terminal phase;
- Reorganization of services for patients in the terminal phase in hospitals, without additional budgets.;
- Integration of this clientele with clientele in residential and intermediate resources (AIDS);
- Funding of ambulatory teams in CLSCs and home-care teams within post-hospital services.
- Training of personnel at each level of the service continuum.

LABORATORIES

3.1.16 Improve the accessibility and efficiency of the laboratory network

The reorganization of medical biology laboratory activities has been underway for several years. Significant progress has been observed for our region in terms of accessibility and efficiency:

- Measures established to offer walk-in specimen collection services in all general and specialized care hospitals and in certain CLSCs have improved accessibility throughout our territory and the increase in volume observed has been absorbed by the institutions concerned, without any additional budgets;
- The closing of hospitals also had impacts on neighboring hospitals without additional resources being assigned and has had the effect of reducing the budget assigned to laboratories by 11%.

Table 12 - DECREASE IN BUDGETS SINCE 1994

Budget 1994-95	$134,263,817
Budget 1996-97 (excluding closed hospitals)	$119,692,955
Total decrease since 1994 : $14,570,862	11%

Table 13 - FISCAL YEAR 1996-97 - DATA PRODUCED ON AS-471 REPORTS

Region	Gross cost of laboratories	Total of weighted units	Cost per weighted units
Montreal-Centre (06)	$130,437,885	143,643,782	$0.91
Total Quebec	**$340,369,543**	**369,568,549**	**$0.92**

In spite of the fact that financial and statistical data for 1996-1997 in the preceding table illustrate a good performance for our region, we believe that additional efforts may be made in terms of accessibility and efficiency.

The efficiency target defined for institutions in the 1997-1998 budget indicate that there is an important potential but the restructuring process will extend over several years and will occasionally require long-term investments; most institutions took advantage of the departure incentive programs to integrate redeployed personnel and review job position structures. In many cases, the savings enabled an increase in volume to be absorbed without additional costs, as well as self-financing of the acquisition or improvement of technical or computer equipment. The impacts on a budgetary level are not always evident, particularly if we take into account the obligations related to equipment acquisition contracts.

Taking the preceding and the current situation into account, the Régie régionale proposes the following measures in regard to laboratory activities:

3.1.16.1 Encourage institutions to apply internal measures to restructure all laboratory activities.

3.1.16.2 Offer walk-in specimen collection services in all CLSCs in the region.

3.1.16.3 Complete the integration of laboratory activities of the residential and long-term care centres and psychiatric and rehabilitation hospitals with a laboratory in a general and specialized care hospital.

3.1.16.4 Ensure the complementarity and efficiency of the laboratory network:

- Maintain cytology activities in laboratories in accordance with the principal recommendations of the Groupe sectoriel provincial;
- Maintain laboratory activities related to analyses of the clientele registered in existing general and specialized care hospitals, or according to inter-institution agreements; →

- Aim for efficient provision of more specialized analyses.

3.1.16.1 Encourage institutions to apply internal measures to restructure all laboratory activities

Description and justification of the measure:
Information collected by the institutions and reorganization project reports confirm information found in documentation to the effect that greater savings are generated by measures within each institution. The message is clear: an in-depth analysis of the ways of doing things aimed at performance and quality is necessary in all the laboratories.
The organizational elements to be considered may be found at different levels:

- Administrative grouping of all laboratories;
- Integration of satellite laboratories and decompartmentalization of specialties;
- Versatility of the staff without loss of expertise with adequate training activities.

It is important to note that the integration and merger projects underway in the CHUM and the MUHC should generate substantial savings on the medium and long terms at the laboratory level.

As for the review of the use of analyses and programming of algorithms, work must be intensified and a follow-up provided if we are to achieve significant results. Computerization of the request-result is of prime importance in facilitating the analysis of data. Positive effects are not always perceptible in the laboratory since they can also generate savings in pharmacy activities and in decreasing the length of stays in emergency departments.

Results targeted:

- Attain the optimum level of efficiency;
- Provide savings for self-financing of projects related to the reorganization or maintenance of access to services in priority programs.

Conditions for performance:

- Establish a mechanism to integrate management of the various laboratories and an advisory committee involving representatives from different professional, technical and administrative levels in order to facilitate the internal restructuring process;
- A detailed analysis of the organizational and functional structure in terms of effectiveness, efficiency and quality level.

3.1.16.2 Provide walk-in specimen collection services in all the CLSCs in the region

Description of the measure:
Improve access to specimen collection services for the clientele in our territory by offering walk-in services at certain hours in the CLSCs and linking them to a laboratory to ensure the speedy return of results to the prescribing physician.

All CLSCs in the Montreal region will be able to offer 4 hours of walk-in specimen collection services, from 7:30 a.m. to 11:30 a.m.

Operational implementation must take into account geographic proximity and agreements already established to minimize transport costs, facilitate professional and administrative interactions and ensure a rapid return of the results to the prescribing physician.

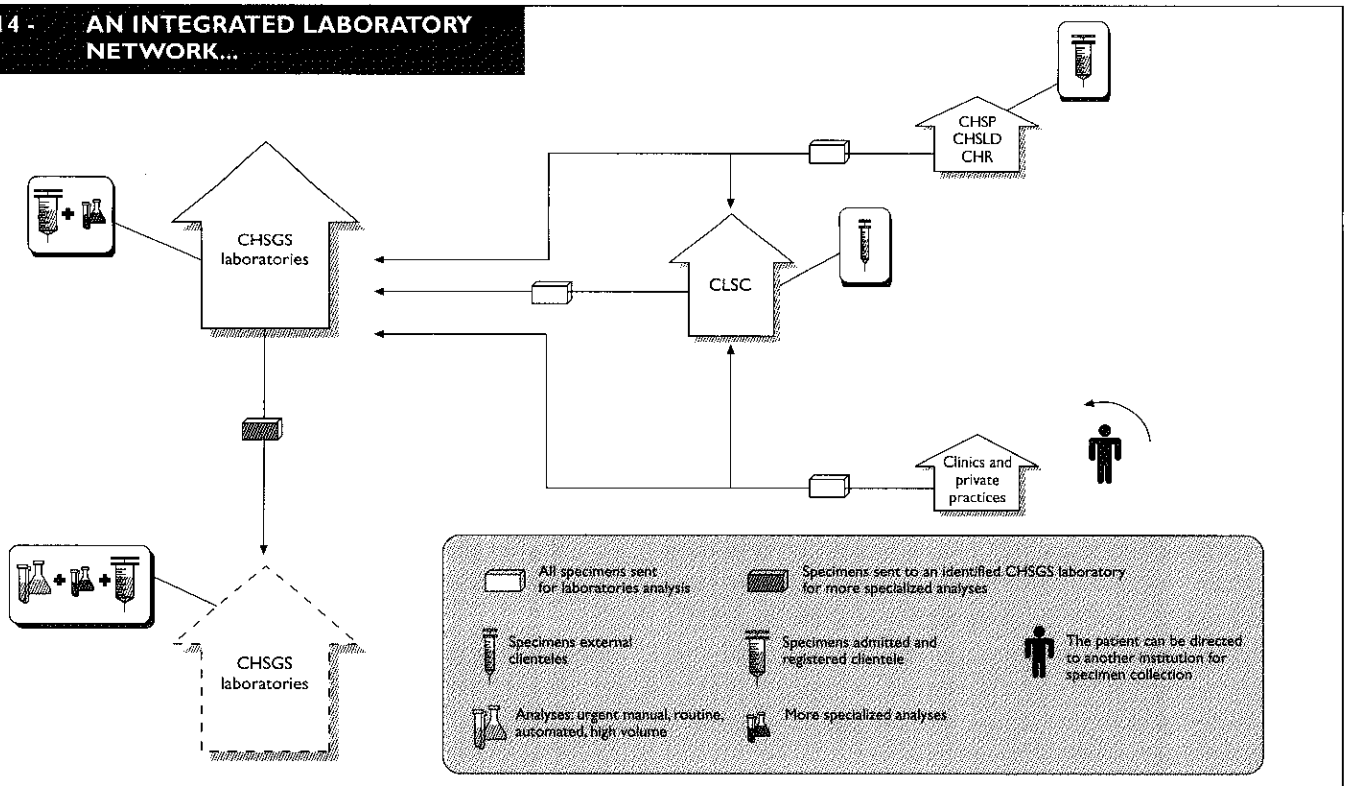
Results targeted:

- Respond to the needs of the clientele by offering services which are more flexible and better adapted to needs;
- Consolidate the CLSCs as first-line institutions.

Conditions for performance:

- Effective communications and transport systems;
- No amount is anticipated for the potential increase in volume of activity in the CLSCs;
- Transport costs assumed by the CLSCs;
- Budget available for renovating premises and the equipment required in the CLSCs.
- Inter-institution agreement protocols including a clause obliging the respect of standards and recommendations issued by the Department in regard to handling and transport of specimens;
- Transfer of resources related to clientele registered in general and specialized care hospitals to the CLSCs on a prorate basis of activity volumes; a comparative study of the number of specimens collected before and two months after application of the measure should ensure equitable distribution;
- Hiring priority for medical technologists based on their expertise;
- Collection of data for measurement units and budgetary charges should be standardized in the CLSCs;
- The joint participation of the CLSCs-hospitals-Régie régionale to maximize the chances of success;
- Adequate communications plan so that clientele are directed to services correctly.

Table 14 - AN INTEGRATED LABORATORY NETWORK...



3.1.16.3 *Integrate laboratory activities in long-term, psychiatric and rehabilitation hospitals in a general and specialized care hospital laboratory*

Synthesis:

This measure involves integrating the laboratory activities of institutions whose mission covers residential and long-term care, psychiatric care and rehabilitation, in laboratories in general and specialized care hospitals. Specimens collected from their clientele will be sent to one of these laboratories to be analyzed. Certain procedures may be carried out on site following an evaluation of specific needs, quality principles and inherent costs.

Justification of the measure:

The analyses required for clientele in these centres could be carried out more efficiently by laboratories which process larger volumes in a more efficient manner. A large portion of the costs is related to specimen collection activities, while purchased services and human and material resources are often under-utilized.

Most of the institutions concerned have already modified their structures by taking advantage of opportunities afforded by voluntary departures. Agreements have been drawn up or are in the process of being finalized and the savings generated have therefore been assigned, for the most part, to budget balancing plans as well as to the voluntary departure program.

Results targeted:

- Improve the quality, effectiveness and efficiency of laboratory services in these institutions;
- Release potential savings which could be assigned to direct care services for patients.

3.1.16.4 *Ensure the complementarity and efficiency of the laboratory network*

Recommendations made by various expert groups at the provincial level in regard to cytology, mycobacteriology, HIV, virology and genetics all focus on rationalizing the number of sites carrying out more specialized analyses. This work has not yet been completed but certain benchmarks have already been specified.

In view of concerns and comments submitted during the hearings by various practitioners involved, in regard to the possible increase in concentration in certain laboratories, such as:

- concern for non-designated general and specialized care hospitals that medical specialists might leave their institutions and that this phenomenon could have a harmful effect on service coverage for their clientele;
- anticipated difficulties in consultations between referring physicians and professional consultants;
- a possible decrease in performance caused by a significant reduction in volume particularly related to employee job security and methods of purchasing equipment;

the Régie régionale proposes the three following orientations:

- **Maintain cytology activities in the laboratories in accordance with the principal recommendations of the Groupe sectoriel provincial**

  This committee of experts recommended a minimum volume of 250,000 slides annually, including gynecology and/or non-gynecology with a permanent staff of 3 cytotechnologists and the presence of at least one pathologist. These standards are required to obtain optimum effectiveness and to maintain the cytotechnologists level of expertise.

  In view of the impossibility of conforming to this in the first year, inter-institution agreements must be drawn up and each cytology laboratory shall be responsible for respecting recognized quality standards in this specialty. It would also be advisable to review the organization of work in each laboratory and evaluate the assignment of duties related to reception, preparation and shipment of the specimens as well as clerical duties, as always, with the goal of reducing operating costs and ensuring effectiveness.

  Timetable : March 1999

- **Maintain laboratory activities related to analyses of external clientele in general and specialized hospitals or according to inter-institution agreements**

  Each CLSC shall establish an agreement protocol with a general and specialized care hospital, considering the following parameters:
  - geographic proximity and existing links;
  - transport methods in accordance with quality standards;
  - respect of the maximum period of 2 weeks for the return of results to the prescribing physician;
  - specimens requiring more specialized analyses will be forwarded by the general and specialized care hospital to a laboratory which performs these tests.

- **Aim for increased efficiency in provision of more specialized analyses**

  More specialized analyses must be grouped together in certain institutions, taking into account the recommendations of the groupes sectoriels d'expertise and work performed at the provincial level.

  Statistics show that 80% of the volume of activities involve routine analyses or analyses considered urgent and that a large number of more complicated or low volume tests are carried out in several institutions at a high cost, taking into account the technical and professional expertise and equipment or supplies required. Therefore approximately 20% of the analyses could be grouped together. This potential will be assessed and decisions made as various projects develop in each specialty. However, the Régie régionale encourages all hospitals to explore the best solutions, with their partners, and to utilize every opportunity available.

  To ensure the reliability and proper operation of the network, laboratories will be responsible for the quality of the entire process, from the collection of the specimen to the return of the result and must introduce mechanisms for integrated management and encourage discussions between professionals. The CLSCs and specimen collection centres are also responsible for the application of the rules and procedures which concern them. All these principles shall be drawn up by a team composed of the various practitioners.

Results targeted:
- Laboratory activities in a complementary and efficient network;
- The provision of quality services in a more effective manner.

Conditions for performance:
- Development of adequate and compatible communications and computerization systems;
- Reduced waiting periods for results;
- Choice of a means of transporting specimens according to quality standards at a more efficient cost.
- Joint purchasing mechanisms for purchasing supplies;
- Self-financing of the costs related to renovating premises and information systems;
- Use of a single analysis prescription form

All sectors of laboratory activities are affected by the reorganization and objectives will be attained in so far as the various partners are all committed to the process. Changes in developing needs of the clientele will influence the offer of services and necessitate adjustments.

Even though the shift toward ambulatory care has little impact on the overall volume of tests, since they come from an outpatient rather than a hospital clientele, the rapid return of results continues to be an important issue in decreasing waiting periods and facilitating diagnoses, whether it be for the emergency department, day surgery, a CLSC or in the home. An increase in volume has been observed and a generalized follow-up of the situation over the next few years to analyze fluctuations in activity volumes will enable the institutions to make the necessary readjustments.

3.2 CONTINUUM OF SERVICES FOR THE ELDERLY EXPERIENCING A LOSS OF AUTONOMY

SOLUTIONS FOR THE FUTURE FOR THE ELDERLY

Institutional placement

3.2.1 Maintain 14,017 beds in residential and long-term care centres and increase the proportion of places for clientele requiring 2.5 hours of care or more per day to 60%

3.2.2 Improve equity of access to services according to the linguistic and cultural characteristics of the population

3.2.3 Improve the rate of response to the needs of people in residential environments

3.2.4 Provide services in residential and long-term care centres adapted to an adult and elderly client with mental health problems or an intellectual impairment

Hospitalization in general and specialized care hospitals for the elderly

3.2.5 Maintain 552 long-term care transition beds in general and specialized care hospitals and reduce the waiting list for people in hospitals who are waiting for institutional placement

3.2.6 Increase the number of elderly people who can actually return home after a stay in hospital and reduce the average length of their stay

Home-care

3.2.7 Consolidate and increase access to CLSC home-care services for people experiencing a loss of autonomy

3.2.8 Ensure the elderly have access to light and heavy housekeeping services subsidized by the government through social economy enterprises

3.2.9 Develop a day centre for the English-speaking community and improve the efficiency and effectiveness of all day centres

3.2.10 Increase beds for temporary placement and improve the efficiency of existing services

3.2.11 Ensure that private residential resources contribute to maintaining the autonomy of the elderly in a safe and high quality environment

3.2.12 Improve partnerships with community organizations and their contribution to the continuum of services for the elderly →

Non-institutional residential resources

3.2.13 Extend the range of services available for clientele by developing 400 places in non-institutional residential resources, including 40 reserved for adults under the age of 65 years.

Prevention and promotion

3.2.14 Enhance promotion and prevention regarding the elderly

Development of an interactive service network

3.2.15 Consolidate the implementation of the CLSC's single window approach for access to long-term services in the community or in institutions

3.2.16 Revise the instruments used in the client profile assessment (CTMSP) and the assessment of services required (PLAISIR)

3.2.17 Support testing of an innovative project concerning integrated services for the elderly experiencing a loss of autonomy (SIPA)

Aging of the population has created new needs and imposed new demands on the health network. It is interesting to note that the population of Montreal is aging more quickly than the rest of Quebec and that this trend will be continuing.

There are 270,000 elderly people today (15% of the population) and this number could reach 370,000 by 2016 (19%). In addition, elderly people, 75 years of age and over, are the group which is increasing most rapidly.

As the Direction de la santé publique reported in its annual report for 1998 on the health of the population:

> "....between 75 and 84 years, disabilities become marked: half the elderly population state they have a disability and after 85 years, this proportion reaches 77%." (p.57).

Principal points raised during the consultation:

The public consultation showed the extent to which the concern of all players is constant in regard to the presence of elderly people in the care and service system.

- There is fear that the proposal presented does not take sufficient account of the increasing needs of the aging population;
- The increase in the number of beds which can receive a clientele requiring 2.5 hours/care per day seems to be of prime importance: it is considered necessary to increase the number of these beds by 60% (rather than 50%) of the beds available;
- A great deal of concern was expressed in regard to the rate of response to needs in residential and long-term care

centres and the quality of services in private residential resources;

- The proposed increase in home-care services was considered insufficient: these services must be intensified and it must be ensured that they can serve an elderly clientele under the age of 65 years;
- The establishment of a complete range of services designed to meet the various needs of the elderly person is important. An additional 100 place in intermediate resources is considered too timid: 400 would be a better estimate;
- Several participants emphasized difficulties in coordinating the various components in the health system.

In view of these points, the Régie régionale has decided to enhance its actions regarding the continuum of services for the elderly, outlined in the proposal submitted for consultation. The following orientations will be used to determine a group of renewed measures:

- Prudence in closing beds in residential and long-term care centres in order to ensure we do not create a bed shortage in the coming years;
- Increase admissions' criteria so that 60% of the beds in residential and long-term care centres can receive people requiring 2.5 hours of care or more per day;
- Increase the rate of response to needs so that all residential and long-term care centres attain the regional standard;
- Increase CLSC home-care services so that they are more intense and attain 80% of the potential clientele;
- Diversify the range of services available by creating 400 places in non-institutional residential resources;
- Continue the establishment of an interactive service network.

INSTITUTIONAL PLACEMENT

Maintain 14,017 beds in residential and long-term care centres and increase the proportion of places for clientele requiring 2.5 hours of care or more per day to 60%

Four important factors have led us to approach additional bed closings in residential and long-term care centres with prudence:

1. The increase in the elderly population particularly those aged 75 years and over (from 111,886 in 1996-1997 to 140,327 in 2001-2002);
2. The proposed decrease (see measure 3.2.6) of the number of transition beds in general and specialized care hospitals from 888 to 552 beds;
3. The transformation of 120 beds in residential and long-term care centres to create non-institutional residential resources;
4. The increase in the use of long-term beds for people under the age of 65 years (1400 beds in 1997-1998 and 1563 beds in 2001-2002).

Table 15

	1997-1998	2001-2002	Deviation
Beds in CHSLD[9]	13,781 [10]	14,017 [11]	+ 236 [12]
Beds in CHSGS	888	552	- 336
TOTAL	**14,669**	**14,569**	**- 100**

To complete the portrait of placements available, the following data should be added to table 15:

- The existence of approximately 1,000 beds in private, self-financed residential and long-term care centres;
- The current availability of 85 places in pavilions and 300 places in nursing homes;
- The proposed addition, in this plan, of 400 places in intermediate resources.

In view of the introduction of new non-institutional residential resources and the increase in home-care budgets, we believe we will be able to deal with the needs for the year 2002 by maintaining 14,017 beds in public and private CHSLDs under agreement.

If we only consider beds for the elderly, our bed ratio passes from 11.9 beds in residential and long-term care centres and general and specialized care hospitals per 100 elderly people aged 75 years and over in 1997-1998, to 9.3 beds in 2002. In order to be able to continue to deal with the increasing demand, we must ensure that 60% of the beds in residential and long-term care centres can receive people requiring 2.5 hours of care or more per day (currently 44%).

Attaining this objective will require a reduction of 2,090 beds for people requiring less than 2.5 hours of care per day and the addition of 2,326 beds for people requiring 2.5 hours of care or more per day. This will allow a better response to the needs of people requiring more intensive care, who form the majority of the clientele to be served (see table 16).

[9] Beds in public and private CHSLDs under agreement

[10] This figure includes 1400 long-term beds for elderly people under the age of 65 years.

[11] This figure includes 1563 long-term beds for elderly people over the age of 65 years.

[12] The increase of 236 beds is broken down as follows :
- A net decrease of 94 beds due to renovation projects;
- The addition of 450 beds to accommodate transfers from Hôpital Ste-Anne;
- The decrease of 120 beds related to the transformation of CHSLD beds into non-institutional residential resources.

Table 16 - DEVELOPMENT OF LONG-TERM BEDS IN CHSLDs 1998-2002

Situation	< 1.5h	1.5 - 2.5h	%	Sub-total	> 2.5h	%	TOTAL
1997-1998	1,053	6,644	55.85	7,697	6,084	44.15	13,781
2000-2002	458	5,149	40.00	5,607	8,410	60.00	14,017
Deviation	**-595**	**-1,495**	**-15.85**	**-2,090**	**2,326**	**+15.85**	**+236**

Means of action to be implemented are as follows:

- Renovate certain residential and long-term care centres so they conform to standards: 3,766 beds would be enhanced to meet needs;
- Reduce the number of beds in certain residential and long-term care centres while enabling institutions to retain their operating budgets, minus the beneficiaries' contributions, in order to intensify services and raise admissions' criteria to accommodate clientele experiencing a more severe loss of autonomy;
- Open 20 additional beds in the Centre d'hébergement et de soins de longue durée Saint-Michel and 20 in the Hôpital Chinois de Montréal, using current financial resources;
- Ensure that 450 beds are transferred from Hôpital Sainte-Anne;
- Add $18.4M to ensure the enhancement where current finances do not allow.

3.2.2 Improve equity of access to services according to the linguistic and cultural characteristics of the population

Improve the balance between the demand and the availability of beds for English-speaking people

At this time, 2,969 long-term beds in residential and long-term care centres and general and specialized care hospitals are affected by the legal obligation to offer services in English to the English-speaking population, representing 20.2% of the beds in the region. The proportion of elderly people, 65 years of age and over whose first official language spoken is English is 31.8%. The percentage of people who speak English in their homes is 26.7%.

To make up for this difference, the following measures are being taken:

- A request has been submitted to the Ministère de la Santé et des Services sociaux to have two residential and long-term care centres where services are available included in the English language access program currently under study: the Centre d'accueil Dollard-des-Ormeaux and the Manoir Pierrefonds. This would add 224 beds to the existing pool.
- Negotiations are underway between the Ministère de la Santé et des Services sociaux and the Federal Government to acquire the Hôpital Ste-Anne-de-Bellevue and to include it in the English-language access program. This would add 450 additional beds;
- By the year 2002, it will also be necessary to add 862 additional beds to the English-language access plan.

Table 17 - BEDS AVAILABLE FOR ENGLISH-SPEAKING PEOPLE

	Beds	Percentage
Current	2,969	20.2 %
2002	4,506	30.9 %

In addition, if feasibility studies are conclusive, we plan to relocate the Centre hospitalier Grace Dart and the Centre de soins prolongés de Montréal in the western sector of the Island in order to improve geographic access to services in these institutions for English-speaking clientele.

Improve cultural adaptation of our services:

In the past, in a different historical and economic context, certain cultural communities were able to develop and become an integral part of the network of public institutions, with special but not exclusive, eligibility criteria for members of their community. This was the case for the Jewish, Italian, Asian, Polish and Lebanese communities.

In the future, we do not plan to continue to develop such institutions. Instead we will improve our response to the needs of the different cultural communities by offering cultural comfort through partial or full programs in existing residential and long-term care centres.

Various steps are being taken with the Jewish, Chinese, Greek and Italian communities in order to preserve or improve access to culturally well-adapted residential services.

During the hearings, the Jewish community presented submissions designed to identify concrete means to improve access to long-term care services for the elderly. The Régie régionale is working with the Jewish community to define the measures which are most pertinent and which present the best possibilities of being achieved.

3.2.3 Improve the rate of response to the needs of people in residential environments

The analysis of the efficiency of residential and long-term care centres carried out as part of the service organization plan for 1995-1998 enabled us to identify increases in efficiency calculated in dollar terms and to determine the targets for internal and external reallocations which would lead to a better response to the needs of the beneficiaries.

However, with the aging of the population, needs are continually increasing: placement is more and more often reserved for the elderly experiencing a serious loss of autonomy and cognitive disorders are more prevalent among elderly people placed in residences. In view of this trend, it is important that the residential and long-term care centres have the resources required to adequately serve their clientele.

Our current methods of analyzing needs have determined that, to attain the regional standard in care and services, an additional $47.8M will be required. This is based, among others, on a rate of response in nursing care and assistance of 80%. To obtain such a large amount, we are counting on efficiency gains to which a development budget will be added.

Means of action to be introduced are:

- Achieve efficiency gains in residential and long-term care centres for a value of $19.2M (3% of the regional budget for public and private residential and long-term care centres under agreement); measures designed to produce these efficiency gains will be introduced in the first year of the plan, that is during 1998-1999;
- An analysis of the effects of the plan for 1995-1998 and, among others, examination of the impact of $33.4M in investments made as part of this plan on the additional resources required to improve the response to needs of persons in residential resources;
- A revision of the current resource assessment tools, in order to determine their pertinence in the current manner of distributing services to the elderly;
- Definition of a common service basket which should be present in all residential and long-term care centres;
- Calculation of the possible gains involved in using current resources according to a benchmarking approach. For the same measured rate of response to needs for similar clientele with comparable results, we observe there are diverse methods of intervening and organizing services, some being less costly than others. The benchmarking method is designed to apply the approach considered best to all the institutions; →
- Evaluation field visits to certain residential and long-term care centres to validate parameters for optimum performance efficiency and to intervene in problem situations;
- An additional $28.6M, to be distributed equitably between the residential and long-term care centres, to deal with the increasing weight in the needs of the clientele.

3.2.4 Provide services in residential and long-term care centres adapted to an adult and elderly client with mental health problems or an intellectual impairment

Currently, the residential and long-term care centres provide services to an elderly clientele under the age of 65 years in approximately 10% of the beds (1,400 beds). This figure has a tendency to increase since the residential and long-term care centres are an interesting environment for certain people suffering from an intellectual impairment, a mental health problem or even a physical impairment.

Over the next few years, 60 people from the mental health network and 103 people from the network for the intellectually impaired are expected to be transferred to residential and long-term care centres (see measures in these service continuums). These projects must be carefully prepared in order to ensure the beneficiaries, their relatives and the organizations which are currently responsible for them, that programs adapted to the specific needs of these clienteles are introduced, as well as all the original network's follow-up mechanisms.

These transfers will be performed with adequate clinical support and sufficient funding.

HOSPITALIZATION IN GENERAL AND SPECIALIZED CARE HOSPITALS FOR THE ELDERLY

3.2.5 Maintain 552 long-term transition beds in general and specialized care hospitals and reduce the waiting list for people in hospitals waiting for institutional placement

Many elderly people are obliged wait in a hospital bed for placement in a residential and long-term care centre. In 1996-1997, 2,696 people waited until a place was vacated in the residential and long-term care centre of their choice. In 1997-

1998, these people occupied 888 "transition" beds in the hospitals. Currently (March 1998) they are occupying around 130 acute-care beds - a phenomenon that we usually refer to as "overflow from long-term care to acute-care".

The public consultation received many comments denouncing the pernicious nature of this situation. Two major reasons were raised:

1. The effect on the congestion in emergency rooms of too many beds occupied by the elderly awaiting placement;
2. The inadequate nature of hospital beds as a living environment for the elderly, in spite of the hospitals' efforts in this regard.

Accordingly, we feel it is important to reduce the number of transition beds in general and specialized care hospitals to 552 and to eliminate the "overflow" phenomenon, while reducing the access waiting period for the elderly who are waiting in a hospital for an institutional placement.

This measure requires the following actions to be performed simultaneously:

- An increase of 2,326 beds in residential and long-term care centres available for beneficiaries requiring 2.5 care-hours or more per day (see measure 3.2.1);
- Maintain the occupation rate in residential and long-term care centres at no less than 99.4%;
- Increase the number of places available in non-institutional residential resources for elderly people who require less than 2.5 care-hours per day (see measure 3.2.13);
- Improve the physical quality of residential resources by bringing some 3,766 beds up to standard;
- Increase the number of elderly people in hospitals who agree to wait for their institutional residential placement in transition beds in a residential and long-term care centre, rather than in the hospital. This measure requires that incentives which respect the rights of the elderly are put in place and that adequate information is provided to the patients and their relatives on the availability and accessibility of institutional residential placement.

3.2.6 Increase the number of elderly people who can actually return home after a stay in hospital and reduce the average length of their stay

The elderly represent a large portion of the clientele in acute-care hospitals: in 1996-1997, 32% of patients hospitalized were 65 years of age or over and accounted for 50% of the days-presence in acute-care hospitalization. It should be remembered that the elderly are approximately 15% of the population in the region.

The average length of stay is generally longer for elderly people than for people under the age of 65 years (12.6 days for the elderly in 1996-1997 vs. 7.97 days for the population as a whole). Even though this phenomenon can be partially explained by the loss of autonomy added to the health problems experienced by the elderly, we feel that, with the appropriate means, elderly people could often return home sooner, thereby, in certain cases, preventing a decrease in their functional autonomy.

With the appropriate actions, it will be possible to reduce the number of requests for residential placement submitted by patients in hospitals.

This measure requires the following actions to be performed simultaneously:

- Maintain acute-care geriatric beds in hospitals and residential and long-term care centres;
- Establish a geriatric consultation team in all the hospitals (assessment and treatment) available for emergencies and the care units;
- Screen for elderly people at risk in emergency departments;
- Ensure the presence of an ambulatory geriatric clinic integrated in the geriatric department;
- Increase the availability of the CLSCs' home-care services (see measures 3.2.7);
- Within the scope of the single window approach, improve the linkages between the hospitals and their first-line partners (geriatric assessment, home-care, attending physician, etc.) and between the hospitals and residential and long-term care centres (geriatric assessment);
- Improve the linkages between partners in the network and community organizations.

All these actions will act to reduce the average length of stay for elderly people in acute-care (which was 12.6 days in 1996-1997, while it was 7.97 days for the population as a whole) as well as reducing the rate of requests for placement[13] (which was an average of 9% in 1997-1998) to 8% for the total region.

[13] The rate of requests for placement is the number of requests for placement made in one year by a hospital, divided by the total number of people aged 75 years or more who are admitted into hospital from the emergency department in the same year.

HOME-CARE

Consolidate and increase access to CLSC home-care services for people experiencing a loss of autonomy

The fact that elderly people experiencing a loss of autonomy are increasingly expressing their desire to remain in their homes for as long as possible with adequate support for themselves and their relatives, combined with the need for the health and social service network to revise its provision and organization of services in order to meet these needs in the years to come, requires that we maintain our efforts in developing home-care services for elderly people experiencing a loss of autonomy, as well as support services for their relatives and natural care-givers.

This means that we must consolidate and increase the accessibility and capacity of the CLSCs' home-care services for people of all ages who are experiencing a loss of autonomy, particularly:

- to increase the volume of clienteles served;
- to increase the intensity of services, when required by the needs of elderly people;
- to increase the number of places in terms of care and/or assistance of up to 2.5 care-hours per day without the necessity for constant or critical supervision;
- to increase the number of hours available for the entire range of services offered;
- to decrease referrals for placement requiring less than 2.5 care-hours/day;
- to re-assess home-care situations requiring more than 2.5 care-hours/day on the part of the CLSCs' home-care services with a view to placement in an intermediate or institutional resource better adapted to these needs.

Our initial proposal only mentioned efficiency measures and did not broach the idea of investing additional funds. However, the consultation has convinced us that, as well as introducing our efficiency measures, needs are such that significant development remains necessary.

Means of action to be introduced are:

- For persons experiencing a loss of autonomy aged 65 years or more, add $17.9M in home-care services and achieve an efficiency gain equal to $5.8M;
  With the assistance of a prudent analysis of data collected in 1996-1997 on the three following parameters: →
  - the percentage of the potential clientele who receive services,
  - the average number of home-care visits (care and assistance),
  - the average number of hours of intervention of all types of services combined,

  we seek to optimize the use of existing resources by setting an objective for all CLSCs to attain the median level of the 8 CLSCs which perform best. The methodology that we are considering seems to indicate that such a possibility does exist. However, in view of the fact that this is the first time such an approach will be used, we plan to perform validation exercises with the CLSCs participation, including evaluation visits in the field in order to determine the true margin available which, at this time, we calculate to be $5.8M.

  The measures designed to produce these efficiency gains will be introduced in the first year of the plan, that is during 1998-1999.

  In the next four years, the combined effect of the additional resources and gains in efficiency will enable the volume of persons served and the intensity of these services to be increased. In concrete terms this means providing services to 80% of the potential (compared to 58% at present) and increasing the number of persons served who require between 1.5 and 2.5 care-hours per day.

- **For persons experiencing a loss of autonomy aged 64 years or less (geriatric profile), add $4.6M in home-care services**

- **Consolidate the CLSCs' 24/7 centres, using an additional budget of $1.1M, in order to ensure an adequate response in unplanned home-care services during the evening, night, weekends and on holidays.**

Ensure the elderly have access to light and heavy housekeeping services subsidized by the government through social economy enterprises

Following decisions made during the socio-economic summit, the Government established a financial exemption fund in the latest budget, to support the need for light and heavy housekeeping services in the social economic sector.

This fund will provide a subsidy of $4.00 per hour for anyone who purchases housekeeping services from a recognized company.

It also includes additional assistance which varies depending on the person's income from $0.20 to $6.00 per hour for the following clienteles: everyone aged 65 years or over; people who are under the age of 65 years who are referred by their CLSC; people receiving a direct allocation and who wish to use this service.

This new program is therefore accessible to all elderly people and can contribute to maintaining a quality environment in the home by enabling access to subsidized housekeeping services.

Since 1995, the Régie régionale has been involved with regional partners in developing this project which has two specific objectives: to offer people who are 65 years of age and over, quality housekeeping services as a complement to home-care services provided by the network, and to create durable jobs in this sector which is practically entirely occupied by undeclared workers.

Currently, eight companies are operating on the Island of Montreal and offer services in the territories of 24 CLSCs. Three other projects are being developed to serve the five other CLSC territories by the autumn of 1998, particularly in the western sector of the Island.

In this new context, the CLSCs will, in several cases, be called on to refer people requiring housekeeping services to these new corporations, particularly if it is the only need identified. This will obviously liberate the services of the CLSC homemakers which will be applied to the many personal assistance needs of their clienteles who are experiencing a loss of autonomy or are handicapped. However, it appears there is some confusion in regard to the possible use by the CLSCs of these corporations for clienteles for whom they already provide housekeeping services.

To ensure the complementarity and availability of services throughout the Island within the next three years, together with the other regional partners, it will be necessary to:

- complete the organization of the services to be offered throughout the territory;
- ensure the offer is developed according to the increase in demand;
- inform the potential clientele of the services as they are developed;
- participate in a regional bipartisan committee responsible for the approval and follow-up of the corporations.
- establish referral and cooperation protocol between the CLSCs and the corporations;
- examine all the difficulties which could arise due to the introduction of these services, in particular the impacts on clientele and the practice of the CLSCs in home-care services;
- evaluate the results obtained with the current exemption chart which corresponds more closely to the reality of sitting services than to services to the elderly;
- facilitate access to services for people who do not have the means to pay the minimum rate of $4.00 per hour.

3.2.9 Develop a day centre for the English-speaking community and improve the efficiency and effectiveness of all day centres

There are 34 day centres on the Island of Montreal:

- 24 are connected to a residential and long-term care centre;
- 6 are connected to a CLSC;
- 4 are connected to an institution with a double mission of CLSC-residential and long-term care centre.

For several years (since the early 1990s) the Régie régionale de Montréal-Centre has noted the need to develop a day centre to serve English-speaking people in the territories of the Côte-des-Neiges, René-Cassin and Métro CLSCs. Currently, these territories are the least well served in the region. In addition, English-speaking people form a long waiting list.

Means of action to be introduced are:

- Establish a day centre in the Centre d'accueil St-Margaret at a cost of $300,000;
- Revise the performance of all day centres with a view to improving effectiveness and efficiency and serving more clientele with existing resources.

3.2.10 Increase beds for temporary placement and improve the efficiency of existing services

In 1996-1997, there were 116 temporary residential places distributed in 31 residential and long-term care centres. The annual occupation rate is around 65% and, at certain periods of the year, attains a ceiling of 75%. The abandonment rate for requests is 17.5%.

In 1996-1997, the demand for temporary residential placement reached 2,051 and, according to statistics, we experienced an annual increase of 14.0%.

Table 18 - TEMPORARY RESIDENTIAL PLACEMENT	1994-1995	1995-1996	1996-1997	% aug. 97 vs '96
Number of requests	1,712	1,799	2,051	14.0 %
Number of admissions	1,007	1,052	1,300	23.6 %

The social emergency program offers 25 beds in five hospitals. The current occupation rate is 72% and can reach a ceiling of 82% at certain periods of the year.

To deal with the increase in demand, we must begin by making the best possible use of our current resources, following which we must increase the number of beds.

Means of action to be introduced:

- Efficiency :
  - Merge temporary residential placement and social emergency programs;
  - Concentrate the activities of these programs in seven residential and long-term care centres, while respecting linguistic and ethnocultural particularities;
  - Extend access to temporary residential beds to all general and specialized care hospitals;
  - Increase the occupation rates to 90% and reduce the abandonment rate;
  - Adjust communication methods between the Régie régionale, the CLSCs and the hospitals to the new realities of the program
- Additional resources:
  - Increase the number of existing temporary beds by 35. This action requires additional resources in order to compensate the designated institutions for the loss of the beneficiaries' contribution; an additional budget of $300,000 will be distributed among the residential and long-term care centres concerned.

3.2.11 Ensure that private residential resources contribute to maintaining the autonomy of the elderly in a safe and high quality environment

The respect of conditions favorable to maintaining the autonomy of the elderly by private residential resources (apartments, rooming and boarding houses, family boarding houses) is an important element in the range of services and resources in the continuum of services for the elderly.

Within this perspective, the Régie régionale will adopt a reference model specifying five elements:

1. The critical threshold in loss of autonomy;
2. Recognition of minimum quality criteria as part of the reference directory;
3. The CLSC as first-line partner;
4. The certification process as a voluntary measure;
5. Roles and cooperation mechanisms between partners.

If these resources agree to meet certain minimum criteria:

- a municipal permit,
- registration,
- a public sign,
- an emergency and evacuation plan,
- public liability insurance, they could be included in a directory prepared and distributed by the Régie régionale.

Means of action to be introduced are:

- The Régie régionale will adopt and distribute a reference model for private residential resources;
- The Régie régionale will prepare and distribute a directory of private residential resources;
- Private residential resources will be encouraged to refer to private certification organizations.

N.B. The increase in the CLSCs' home-care budget (see measure 3.2.7) will enable their increased presence in private residential resources.

3.2.12 Improve partnerships with community organizations and their contribution to the continuum of services for the elderly

Community organizations dispense services which are very important for the elderly in the region. The commitment of volunteers should be noted for their determining contribution, particularly for the elderly person who wishes to remain in his/her natural environment.

Reallocations made over the past three years enabled community organizations working with the elderly to consolidate their activities and increase their accessibility.

However, community organizations are constantly confronted by new situations and new problems which require adopting renewed means of action. This is the case, in particular, in accompaniment/transport, meals and adjusting interventions for people with mental health problems.

- **Accompaniment/transport:** The shift toward ambulatory care creates an increasing need for accompaniment/transport services, which exerts a great

deal of pressure on community organizations;

- **Meals:** The extension of the traditional concept of delivering meals is to be encouraged in order to include the concept of community meals and providing a presence during the meals.
- **Mental health:** There has been an increase in requests for services from people who have mental health problems. This requires that volunteers who work intensively with this clientele are provided with adequate support.

In choosing means of action, it is important for the Régie régionale to act with community organizations, while respecting the orientations, policies and approaches which the organizations themselves have chosen.

The means of action proposed is:
To work with the Coalition pour le maintien dans la communauté des personnes âgées/COMACO (coalition to maintain the elderly in the community), in order to identify possible actions to deal with the new challenges facing community organizations.

NON-INSTITUTIONAL RESIDENTIAL RESOURCES

3.2.13 Extend the range of services available for clientele by developing 400 non-institutional residential resources, of which 40 are assigned to adults under the age of 65 years

There are very few resources between the home and institutional placement: four pavilions (a total of 85 places) and approximately 300 places in nursing homes.

The intensification of admissions' criteria in residential and long-term care centres and the significant decrease in the availability of beds offering less than 2.5 care-hours per day, calls for alternate solutions to be found for clientele who require less than 2.5 hours of care per day.

Clientele who need less than 1.5 care-hours of services per day without requiring supervision should have their needs covered by home-care services and private resources. On the other hand, clientele requiring less than 1.5 hours of care per day who have behavioral problems should be received in residential and long-term care centres, as well as clientele requiring between 1.5 and 2.5 care-hours per day with need of supervision.

Non-institutional residential services are therefore designed for two clienteles:

- Clientele requiring less than 1.5 care-hours of services per day with a need for supervision, but without behavioral problems;
- Clientele requiring between 1.5 and 2.5 care-hours of services per day without need of supervision.

We estimate that approximately 650 requests per year for this type of clienteles are made to the regional admissions' system and that a substantial portion could benefit from placement in a non-institutional residential resource.

The introduction of non-institutional residential resources involves allocating funds to the resource itself for housing, food and assistance. It requires that the responsible residential and long-term care centre provide a structure and follow-up for the beneficiaries.

We estimate that a cost of $6.1M (not including the beneficiaries' contribution) is required to establish 400 places, of which 40 will be assigned to clientele under the age of 65 years. The transformation of 120 beds in residential and long-term care centres will enable the creation of these 400 places.

PREVENTION AND PROMOTION

3.2.14 Enhance promotion and prevention regarding the elderly

The situations which have the most impact on the ability of the elderly to preserve their autonomy and continue to live in their natural environment include:

- the psychological equilibrium of the elderly person and natural care-givers;
- poor treatment;
- falls;
- influenza
- the inappropriate use of medication.

We have therefore chosen among several possibilities for promotion of health and prevention activities, to focus on those which have a bearing on these situations.

The following means of action should be introduced:

Prevention of depression:

- Intensify strategies to prevent elderly people living in their homes and in institutions from becoming isolated and feeling they are alone;
- Facilitate the implementation of support programs for the elderly and their care-givers during stressful events such as

retirement, mourning, institutionalization;
- Intensify screening and treatment of depression among elderly people living in their homes and in institutions.

Prevention of abuse and negligence:
- Intensify strategies to prevent or recognize situations of abuse and negligence among the elderly and their natural care-givers, when requests are submitted for admittance to a home-care program, as well as through Info-santé and various programs designed to maintain the elderly in the community;
- Establish applicable intervention protocols as well as a network of referral practitioners for clientele at risk of abuse and negligence.

Prevention of falls:
- Introduce effective fall prevention programs in residential and long-term care centres, rehabilitation centres and for clientele of the CLSC home-care program;
- Facilitate access to community programs to improve balance for autonomous elderly people living at home.

Prevention and control of influenza:
- Increase vaccination coverage to 80% among beneficiaries in closed environments and to 60% in the open environment;
- Increase vaccination coverage of care personnel;
- Assist the residential and long-term care centres to prevent, recognize and control influenza in their environment.

Prevention of morbidity associated with poor use of medication:
- Organize an annual information campaign designed to encourage the elderly to have their list of medications revised by their physician;
- Promote the use of memory-aid methods to facilitate respect of the pharmacological treatment;
- Continue experimentation through the research project "Pratique médicales de l'avenir (PMA)" (Medical practice for the future), designed to assist in the pharmacists' and physicians' decision-making process, with the objective of reducing the number of inappropriate prescriptions.

DEVELOPMENT OF AN INTERACTIVE SERVICE NETWORK

The development of a range of diversified services adapted to needs and in sufficient quantity is the cornerstone in responding to the needs of the elderly in our region. All the measures described in the preceding pages are designed to meet this challenge over the next four years.

However, the availability of resources is not everything. Because the services are highly diversified, it is imperative that they compose a true network if we wish to ensure the continuity of the services and the efficiency of the resources

2.1.1 Consolidate the implementation of the CLSC's single window approach for access to long-term services in the community or in institutions

We must continue implementing the single window approach established in the plan for 1995-1998.

The means of action to be implemented are as follows:
- Apply the hospital-CLSC-attending physician linkage mechanisms established for post-operative and post-hospital care to the single window approach;
- Develop common referral tools;
- Simplify relations between institutions by decreasing the complexity of procedures;
- Improve the use of screening tools for elderly people at risk;
- Improve the links between the CLSCs and the attending physicians;
- Continue the case management training program.

2.1.2 Revise the instruments used in the client profile assessment (CTMSP) and the assessment of services required (PLAISIR)

Several factors raise questions concerning the pertinence of the current tools used in assessing needs and measuring the rate of response to needs, as well as the resulting instruments and procedures which form the regional admissions' system for residential and long-term care environments:
- Adjustment of assessment tools to the current service provision models;
- Simplification of procedures and the pursuit of additional efficiency gains;
- Adjustment of the assessment and coordination tools to natural developments in the care and service system;
- Revision of legal mandates assigned to the regional boards;
- Introduction of the single window approach.

3.2.17 Support testing of an innovative project concerning integrated services for the elderly experiencing a loss of autonomy (SIPA)

A team of researchers from the McGill University and Université de Montréal networks have approached the Ministère de la Santé et des Services sociaux and the Régie régionale de Montréal-Centre with a proposal for a project referred to as SIPA (a system of integrated care for the frail elderly).

This project is based on the principle of capitation and a territorial management approach for the elderly population experiencing a loss of autonomy. It proposes integrating clinical, organizational and financial aspects of medical services and health services as well as the social and community services necessary for vulnerable elderly people.

The Régie régionale is extremely interested in this project and desires its implementation.

Table 19 - BREAKDOWN OF DEVELOPMENT BUDGETS FOR THE FOUR YEARS OF THE PLAN 1998-2002

	Year				
	I	II	III	IV	Total
Intensification of 2326 beds	0	3.6	7.4	7.4	18.4
Increase in the rate of response	0	5.6	11.5	11.5	28.6
Increase in CLSC home-care services	0	4.6	9.5	9.5	23.6
Increase in temporary placement services	0		0.3		0.3
Introduction of a day centre	0	0.3			0.3
	0	**14.1**	**28.7**	**28.4**	**71.2**
		19.8	**40.3%**	**39.9%**	**100%**

This demonstration project is to be performed in several sites in the region and will involve partner institutions, particularly CLSCs, general and specialized hospitals and residential and long-term care centres. Already in the preparatory phase, the demonstration project itself is expected to run for at least two years, 1998-1999 and 1999-2000.

The Régie régionale is counting on the results to clarify its orientations and decisions in regard to the type of service organization desirable for the elderly experiencing a loss of autonomy in the future. The Régie régionale is prepared to support the performance of this project with the participation of the partners involved.

Funding of the demonstration project is provided through a non-recurring subsidy from the Federal Government's Health Service Adjustment Fund and through contributions made by the participating institutions.

3.3 CONTINUUM OF SERVICES FOR PEOPLE WITH PHYSICAL IMPAIRMENTS

SOLUTIONS FOR THE FUTURE FOR PEOPLE WITH PHYSICAL IMPAIRMENTS

Improve the efficiency of intensive functional rehabilitation services for adult clientele with physical impairments

3.3.1 In the immediate future, maintain access to 731 intensive functional rehabilitation beds by improving the efficiency of programs in the 5 IFRUs in residential and long-term care centres and by optimizing the use of day centres.

3.3.2 Allocate a development budget of $1.7M to the CLSCs in the region in order to offer intensive functional rehabilitation services in the home for clientele who could benefit from this approach.

3.3.3 Optimize the links between the interventions provided by rehabilitation hospitals and IFRUs in residential and long-term care centres with the institutions providing services before and after their interventions.

Improve access to services providing support in the community

3.3.4 Allocate $5.6M over three years to the POSILTPH budgets in the 29 CLSCs in order to eliminate the waiting list and increase access to intensive home-care services for people under the age of 65 with a physical impairment.

3.3.5 Allocate $1M for the CLSC subsidy program to support families of people with physical impairments in order to eliminate the waiting list, ensure a response to new families to be served each year and to enable subsidies to be increased.

3.3.6 Organize under one management authority, budgets for the loan and granting of equipment required for clientele to return or remain at home and therefore, transfer the $400,000 fund assigned for loans of specialized equipment to the Régie régionale.

Consolidate rehabilitation focusing on social integration

3.3.7 Improve understanding of certain problems in order to orient our actions for the future. →

Improve the response to the needs of specific clienteles

3.3.8 Allocate a development budget of $75,000 to the "Centre de distribution des aides techniques/C.D.A.T." (technical aids distribution centre) to diversify and increase the services it provides.

3.3.9 Offer information and training sessions if necessary to the general and specialized care hospitals and to the CLSCs in collaboration with the organization devoted to this clientele.

Principal points raised during the consultation:

During the hearings, our partners expressed their concerns in regard to the following elements:

- that waiting periods for intensive functional rehabilitation (IFR) services must be eliminated, particularly for clientele in general and specialized care hospitals who have had a cardio-vascular accident;
- that clientele currently served in intensive functional rehabilitation units in residential and long-term care centres, due to certain specific medical conditions, are not admitted to rehabilitation hospitals;
- that the consolidation of out-patient services may cause transport problems for the clientele;
- that the CLSCs' role in regard to intensive functional rehabilitation must be better defined:
- that a common and clear definition of what is meant by intensive functional rehabilitation must be developed;
- that personalized results objectives must be set for the institutions involved;
- that a regional service plan for people with physical impairments must be developed;
- the lack of coordination, for people with multiple handicaps, between the network for people with intellectual impairments and the network for physical impairments was strongly criticized;
- it was proposed that the approach in CLSCs should be standardized.

Target clientele:

Clientele with a physical impairment are people with a hearing, motor, speech, language function, or visual impairment. The continuum of services for people with a physical impairment covers clientele of all ages (children, adults, the elderly) for whom an illness, traumatism or congenital defect has caused a temporary disability, or will most probably and imminently result in significant and persistent disabilities and who are, or who risk, experiencing situations in which they will be handicapped.

Orientations:

This improvement plan is based on establishing a continuum of integrated services for people with physical impairments in which all activities will focus on the clientele. The background against which this service continuum will be implemented is particularly characterized by an integrated approach to care and services, from acute-care through rehabilitation to the return to the natural living environment, and involving the full social participation of the individual. This vision held by the Régie régionale requires the cooperation of all players concerned by the plan if it is to be established successfully so that our society can profit from all its benefits.

Objectives:

- **Improve access and eliminate waiting periods for intensive functional rehabilitation services**
  Although significant results have been achieved in the organization of intensive functional rehabilitation services in the region, current trends indicate that we must continue on the same track in order to improve access to IFR services and, in general, the entire range of services for physical impairments.

- **Consolidate rehabilitation services focusing on social integration and integration support**
  Rehabilitation services focusing on social integration and integration support are a fundamental link in the chain of services for physical impairments. In addition to intensive functional rehabilitation, it is important to ensure that the rehabilitation services provided enable the full and complete social participation of people with physical impairments. It is therefore essential to consolidate this stage in the service continuum.

It should also be mentioned that rehabilitation activities are not only provided to clientele from general and specialized care hospitals on their path toward the return home, passing through a rehabilitation hospital in a linear manner. Many people with physical impairments, for example people with active pathologies residing at home, require, on an intensive or non-intensive basis, occasional or continuous rehabilitation services, particularly rehabilitation focusing on social integration, without ever being hospitalized in an acute-care hospital.

- **improve access to support services in the community:**
  The range of services for physical impairments would not be complete without support in the community and socio-residential resources which can provide the optimum quality of life for people, whether they live at home or in a substitute living environment.

To summarize:

The Plan to improve services for 1998-2002 proposes measures to improve intensive functional rehabilitation services and pursues objectives covering all stages of the continuum of services for the physically impaired. These objectives involve rehabilitation services based on social integration and integration support, as well as substitute residential services for all clientele with physical impairments, including multiply handicapped people and those who are pathologically obese, while taking the specific needs of the various cultural communities into account.

- **Improve the efficiency of intensive functional rehabilitation services for adult clientele with a motor impairment:**
  In the region, 731 intensive functional rehabilitation (IFR) beds for adult clientele are currently available in eleven institutions, that is six rehabilitation hospitals including the Institut de réadaptation de Montréal, and five intensive functional rehabilitation units (IFRU) in residential and long-term care centres. The following table presents the distribution of IFR beds in these institutions.

Institutions	Rehabilitation beds
Rehabilitation hospitals	
Institut de réadaptation de Montréal	102
Catherine Booth Hospital	72
Hôpital Marie-Clarac	108
Hôpital de réadaptation Lindsay	135
Richardson Hospital	42
Hôpital Villa Médica	122
IFRU in CHSLD	
CHSLD Champlain-Manoir de Verdun	27
Centre hospitalier J.-Henri Charbonneau	33
Hôpital Notre-Dame de la Merci	20
Centre hospitalier Jacques-Viger	25
Institut universitaire de gériatrie de Montréal	45
TOTAL	**731**

It should be noted that most rehabilitation hospitals also offer IFR services on an out-patient basis; however, the development of these services is irregular. The five residential and long-term care centres with IFRUs also operate day hospitals in which rehabilitation is one of the mandates, together with geriatric assessments, to which must be added the four other day hospitals in the region: the Lakeshore General Hospital, the Royal Victoria Hospital, Centre hospitalier de Lachine and Maimonides Geriatric Hospital. Certain IFR activities are also offered on an out-patient basis by the two motor impairment

rehabilitation centres, Centre de réadaptation Constance-Lethbridge and Lucie-Bruneau.

With the exception of the Institut de réadaptation de Montréal (IRM), the clientele served by the rehabilitation hospitals and the IFRUs in residential and long-term care centres is mainly composed of elderly people over the age of 65[14]. The average age of clientele treated at the Institut de réadaptation de Montréal is 45.3 years, while the average age of clientele in the other rehabilitation hospitals is 71.1 years. The average age of clientele treated by the IFRUs in general and specialized care hospitals is 4 years older (75.1) than in the rehabilitation hospitals, except for the Centre hospitalier Richardson where the average age is 75.8 years. This situation is explained by the fact that there are no IFRUs in general and specialized care hospitals in the English network and that clientele are directed to English rehabilitation hospitals, principally the Richardson Hospital.

All institutions offering IFR services receive clientele with orthopedic or neurological problems, except for the IRM which does not have an orthopedics program. This institution reaches a slightly different clientele from the other institutions, including clientele requiring ultraspecialized services (cranium/brain traumas and medullary injuries). This explains why the average age of clientele treated at the IRM is lower than in the other institutions. Three rehabilitation hospitals also offer rehabilitation services to amputees. Hôpital Villa Médica also receives serious burn victims in need of IFR.

It should be noted that approximately 30% of the clientele served by all these institutions come from another administrative region . However the IRM differs from the other institutions in that more than 60% of its clientele come from another region.

Problems identified:

Trends observed indicate that we must continue our efforts to reduce the length of stay in intensive functional rehabilitation. According to documentation and certain pilot projects underway, we can state that it is probable that lengths of stay in IFR can be reduced. For example, a comparison of lengths of stay in two rehabilitation institutions in which one offers services 7 days per week, indicated an average length of stay of 9 days less for arthroplasty of the knee and 7 days less for arthroplasty of the hip in the institution which provided services 7 days/week, although other factors can influence the average length of stay.

It is also probable that admissions in rehabilitation hospitals or IFRUs could be avoided if certain users, currently oriented to an intensive functional rehabilitation bed, returned home following a hospitalization in a general and specialized care hospital, by taking advantage of intensive functional rehabilitation out-patient services in rehabilitation hospitals, day hospitals, or at home provided by CLSC professional for a clearly identified clientele.

It should be emphasized that twelve general and specialized care hospitals in the region, including the Centre hospitalier de l'Université de Montréal and the McGill University Health Centre, as well as several hospitals in other regions, refer a diversified clientele, sometimes with associated problems, such as cognitive disorders, to eleven institutions which provide intensive functional rehabilitation services without a clearly defined service corridor and according to admissions' criteria that have not been defined on a regional basis. Out-patient services are also irregularly distributed and, even there, no benchmarks have been specified to orient clientele to the resource that is best suited to their needs. Transport problems experienced by a portion of the clientele also make it difficult to achieve the full potential of these resources.

Choosing an option to improve services:

Work performed until now, indicates that it is still possible and would be beneficial for the clientele to increase the efficiency of intensive functional rehabilitation services.

Various points of view were expressed in regard to choosing an organization scenario liable to improve the efficiency of services while responding to the needs of the clientele with accessible and high quality services.

The notice issued by the Commission médicale régionale, received on May 21, 1998, particularly led us to take into account differences in the clientele served by the IFRUs in the residential and long-term care centres.

To summarize, the Commission indicated that the clientele of IFRUs in residential and long-term care centres differ from the clientele in rehabilitation hospitals; these individuals are at greater risk, are more unstable and older, presenting a geriatric profile with multiple pathologies. Their numbers are regularly increasing with the aging of the population, particularly the group aged 75 years and over. According to the members of the CMR, the IFRUs in rehabilitation and long-term care centres have developed very specific expertise for this geriatric clientele and their organization, both medical as well as professional, is adapted to the needs of this clientele. They also noted that, without this expertise in the IFRUs, there is a

[14] Data concerning the age of the clientele served by the institutions offering IFR services also include clientele admitted to these institutions in programs other than IFR.

risk of increasing transfers to acute-care hospitals.

Taking into account:

- work performed to date,
- notices received during the public hearings,
- the notice issued by the CMR,
- heavy trends in the field of rehabilitation and geriatrics: intensification of services 7 days/week, increase in out-patient services, development of rehabilitation services in the home, development of new geriatric approaches related to the aging of the population.

We consider that the path to improving efficiency and organization of services, with concern for all clienteles, may be achieved through the following measures:

TO IMPROVE THE EFFICIENCY OF INTENSIVE FUNCTIONAL REHABILITATION SERVICES FOR ADULT CLIENTELE WITH A MOTOR IMPAIRMENT

3.3.1 In the immediate future, maintain access to 731 intensive functional rehabilitation beds by improving the efficiency of programs in the 5 IFRUs in residential and long-term care centres and by optimizing the use of day hospitals

This approach will involve:

- using the appropriate instruments, perform an analysis of the clientele profile in residential and long-term care centres and in rehabilitation hospitals in order to assess needs and secure the services required by these clienteles;
- by September 1998, establish result and efficiency objectives for the 5 residential and long-term care centres which manage the IFRUs. Efficiency gains will be reinvested in services to the clientele to be determined in accordance with the best practices.

In particular, we will examine the lengths of stay, possibilities of intensifying services adapted to the clientele to 7 days/week, waiting periods for access and admissions' criteria.

We will also draw up a complete list of the utilization of day hospitals and propose measures to optimize these services as well as the means of transport at their disposal.

3.3.2 Allocate a development budget of $1.7M to the CLSCs in the region in order to offer intensive functional rehabilitation services in the home for clientele who could benefit from this approach

Development of IFR services in the home:

A development budget of $1.7M will be granted to the CLSC network for the provision of IFR services in the home and other types of services which will be required in the home by this clientele.

This measure principally targets clientele with an orthopedic problem, such as patients who have had an arthroplasty of the hip or knee and whose clinical and psychosocial condition enables such an approach. Recent documentation from the United States indicates that a large number of clientele for arthroplasty of the hip were able to return home from an acute-care hospital according to a protocol adapted to the physical condition and social environment of the person. While we cannot compare ourselves integrally to the American experience, it is clear that a portion of this clientele could return home directly with the appropriate services.

This measure will be implemented in the form of pilot projects which must include:

- the preparation of clientele selection criteria;
- planning of the discharge at the time of the pre-operative assessment;
- development of hospital-CLSC care protocols;
- preparation of inter-institution liaison mechanisms;
- development of results indicators.

3.3.3 Optimize the links between the interventions provided by rehabilitation hospitals and IFRUs in residential and long-term care centres with the institutions providing services before and after their interventions

Within the context of an integrated service network, the linkage of interventions between the general and specialized care hospitals, rehabilitation centres, out-patient services in rehabilitation hospitals, day hospitals and CLSCs becomes a central measure. We propose the following means:

- Intensify early rehabilitation interventions in general and specialized care hospitals;
- Consolidate discharge planning activities in acute-care as well as in rehabilitation with institutions offering care in continuity to their interventions;
- Set admissions' criteria for rehabilitation hospitals and

IFRUs on a regional basis, taking into account that geriatric expertise is available in residential and long-term care centres, so that all clientele receive a response adapted to their needs;
- Establish service corridors between general and specialized care hospitals and institutions offering intensive functional rehabilitation;
- Benchmark the orientation of clientele to IFR out-patient resources;
- Develop inter-institution care protocols.

Achieving the first two objectives will also be facilitated by therapeutic geriatric consultation teams established in the general and specialized care hospitals as part of the continuum of services for the elderly. In fact, operationalization of the preceding must be performed jointly with certain measures provided in the continuum of services for the elderly and the continuum of physical health services.

IMPROVE ACCESS TO SERVICES PROVIDING SUPPORT IN THE COMMUNITY

Support services in the community do not only involve the CLSC home-care services, they also include services provided by several other institutions or organizations to support families and relatives and to encourage people with physical impairments to remain in their natural living environment. This means that, not only do they include services provided by the CLSCs, but also respite and emergency care offered, for example, by institutions such as the Centre de réadaptation Lucie Bruneau or community organizations and designed for both pediatric and adult clientele.

3.3.4 Allocate $5.6M over three years to the POSILTPH budgets in the 29 CLSCs in order to eliminate the waiting list and increase access to intensive home-care services for people under the age of 65 with a physical impairment

We will be adding $2.1M to the $3.5M already provided in our initial proposal in order to take into account handicapped people between the ages of 60 and 64 years inclusively who were not specifically covered by this program before.

From 1995 to 1998, budget reallocations were made to the CLSCs to improve access to home-care services, particularly for people under the age of 65 with a physical impairment (POSILTPH program). These budget reallocations have enabled more people to be served, but resources currently assigned for this purpose are still not sufficient to meet all the needs of people with physical impairments in need of home-care services.

It should be mentioned that attrition in home-care services for people with a physical impairment is low. It does not allow for new requests for home-care services from a younger clientele who would be able to remain in their natural living environment for several years with the appropriate support. It is also important to ensure that, once the rehabilitation process has been completed, rehabilitation clientele can return home immediately in order to avoid inappropriate use of resources in hospitals or rehabilitation centres.

3.3.5 Allocate $1M for the CLSC subsidy program to support families of people with physical impairments in order to eliminate the waiting list, ensure a response to new families to be served each year and to enable subsidies to be increased

Maintaining people with physical impairments in the community is not effective if the appropriate support measures are not provided for their families and relatives. However, resources assigned for this purpose are insufficient, as is demonstrated by the waiting list for the subsidy program offering support to families administered by the CLSCs.

It should be noted that this program serves clientele with physical impairments as well as intellectual impairments, in a respective proportion of 30% and 70%. An investment in this program is therefore also planned as part of the continuum of services for people with intellectual impairments.

3.3.6 Organize under one management authority, budgets for the loan and granting of equipment required for clientele to return or remain at home and therefore, transfer the $400,000 fund assigned for loans of specialized equipment to the Régie regionale

Returning or remaining at home for certain people with a physical impairment is conditional on the availability of equipment necessary for daily life activities and domestic life activities, such as bath benches or patient-lifters. The Plan for 1995-1998 had appointed a rehabilitation institution as the trustee to manage a $400,000 fund for the loan of specialized equipment required for the return home of clientele who had completed the rehabilitation process in an institution. These equipment loans are performed as a lease until the user can acquire the equipment needed for the long-term through one of the programs which finance the purchase of this type of equipment.

Several programs actually offer financing for purchases of this type of equipment: the "fonds de suppléance" administered by the Régie régionale, the OPHQ "Programme d'aide matérielle" (equipment assistance program) and special benefits for clientele on income security. The latter two programs will shortly be transferred to the regional boards. This measure will be accompanied by a revision of the management methods of the various programs concerning equipment required in the home by clientele with a physical impairment, in order to improve coherence and efficiency.

CONSOLIDATE REHABILITATION FOCUSING ON SOCIAL INTEGRATION

3.3.7 Improve understanding of certain problems in order to orient our actions for the future

An inventory must be prepared of rehabilitation services which focus on social integration and integration support currently available, in order to prepare a service organization model for adult clientele with a motor impairment.

Rehabilitation services focusing on social integration are part of the continuity of intensive functional rehabilitation. Although on the conceptual level they are two separate phases in the rehabilitation process, at a clinical level, these two phases are juxtaposed.

In the Montreal-Centre region, two rehabilitation centres specifically orient their services to provide rehabilitation focusing on social integration and integration support for adults with a motor impairment: the Centre de réadaptation Lucie Bruneau et the Centre de réadaptation Constance-Lethbridge.

Their interventions are mainly designed to continue the person's adjustment to his/her condition and to ensure the optimum development of his/her physical, psychosocial, socio-residential, occupational and community autonomy with a view to full social participation. These interventions are completed by integration support measures dispensed in complementarity with the CLSCs and community organizations.

The services of the Lucie Bruneau and Constance-Lethbridge centres are mainly dispensed on an out-patient basis. Only the Centre de réadaptation Lucie Bruneau offers services to admitted beneficiaries, with 44 beds currently available, of which 12 are assigned to respite and emergency care. It is also the only rehabilitation institution to intervene on a socio-residential level, that is it acts on the development or recovery of the individual's optimum level of socio-residential autonomy through substitute residential resources (islands of services or other resources). In addition to the use of these resources as rehabilitation intervention means, they are also used as a substitute living environment for clientele who cannot return to live in their natural living environment.

The Plan for 1995-1998 dealt particularly with intensive functional rehabilitation services for adult clientele with a motor impairment, one stage in the rehabilitation process. In addition to consolidating IFR services, it is now also necessary to orient our efforts to organize rehabilitation services focusing on social integration and support for integration.

The service organization model to be prepared must include adapting the entire range of services required, according to the needs of the clientele. This offers an opportunity to redefine the services to be provided, the institutions designated to offer them and to readjust the offer of services according to the needs of the clientele and the respective missions of the organizations. This operation could involve a reallocation of human resources and, necessarily, an optimization of the use of resources in place.

- **Draw up a list of adaptation/rehabilitation services provided for the following clientele:**
  - **pediatric with a motor impairment;**
  - **with a sensory impairment (all ages);**
  - **with language and speech disorders (all ages).**

As is the case for social integration rehabilitation services for adult clientele with a motor impairment, little information is available concerning the above-mentioned clientele that would offer a true and complete portrait of the accessibility of rehabilitation services. For this reason, once again a proposal is being made to document the situation in order to identify priority zones of action.

- **Inventory the various types of support services currently available for families living with a person with a physical impairment in order to adapt the range of services offered to the diverse needs of families and to make them as efficient as possible.**

Measures offering support to families must be varied, not only in order to take into account the needs of people with physical impairments, but also the diverse needs of each family in terms of respite and emergency care.

Various types of support are currently accessible to families. However, it is important to ensure that the services available meet the needs of all families; that is that the methods of the

services available can provide a response adapted to the particular needs of people with a physical impairment and their families. More specifically, even though the subsidy program for support to families administered by the CLSCs meets the needs of some families, others must seek different resources for respite-care which will enable them to live a satisfying life. These may include family-type or intermediate resources, community resources or even temporary beds.

In addition to respite and emergency services, it should be emphasized that the needs for sitting services for certain adults with a physical impairment are an integral part of the family's needs. This is particularly the case for families living with a person who has both physical and intellectual impairments. This measure is proposed within the context that appropriate family support services are an essential condition in maintaining clientele in their natural living environment.

- **Introduce non-institutional residential resources for people with a physical impairment whose needs-profile corresponds to clientele usually directed to a residential and long-term care centre, by transforming long-term beds in residential and long-term care centres.**

Various substitute residential environments are currently available, depending on the type and intensity of the needs for care and services of people with physical impairments: family-type resources, intermediate resources, long-term beds in general and specialized care hospitals for pediatric clientele and residential and long-term care centres.

These resources are currently the only ones that meet the needs of persons requiring intensive care and services. In fact, certain resources, referred to here as "resources offering an alternative to residential placement", created through the initiatives of certain existing institutions or community groups do exist, but in extremely limited numbers.

The availability of substitute residential resources must take into account the diversity of the needs of the clientele to be served, since there is a consensus that the offer of services concerning substitute residential environments for clientele with a physical impairment is not sufficiently diversified. In fact there is a clientele, often young, whose needs exceed the capacities of family-type and intermediate resources and who would benefit from non-institutional resources. The objective of this measure, also presented in the continuum of services for the elderly, is therefore to diversify the offer of substitute residential services for clientele with a physical impairment.

It should also be noted that family-type and intermediate resources for clientele with a physical impairment mainly receive clientele with motor impairments. These resources are under the jurisdiction of institutions which serve clientele with a sensory or intellectual impairment.

Currently, these institutions must respond to the needs of clientele who suffer from both a physical and intellectual impairment, referred to as multiply handicapped clientele, particularly due to the physical adaptations which must be made to the resources for this clientele. In this regard, the development of places in intermediate resources for clientele with multiple handicaps is planned and will be presented within the continuum of services for people with intellectual impairments.

Schedule:

As the assessments concerning social integration rehabilitation services are completed, by March 1999, the results will be used to draw up proposals which will then be submitted to the Board of Directors for approval. However, if opportunities occur earlier, measures may also be prepared and presented to the Board of Directors for approval.

IMPROVE THE RESPONSE TO THE NEEDS OF SPECIFIC CLIENTELE

Services for multiply handicapped people:
The term multiply handicapped refers to people who have two associated impairments such as deaf-blindness, motor and sensory impairments or both a physical and an intellectual impairment. However, in this case, special attention is focused on the needs of people with a combined motor and intellectual impairment.

Measures concerning services for people with a physical impairment also apply to multiply handicapped people. However, a special problem is noted for this clientele. Their needs require a joint and coordinated approach between institutions working in the fields of intellectual impairment and physical impairment. Since, as was mentioned in regard to the continuum of services for people with intellectual impairments, this necessary collaboration between institutions is not always present, a means of action has been proposed within the continuum of services for people with intellectual impairments. Nevertheless, work must be carried out in order to ensure that the multiply handicapped receive services adapted to their condition.

Services for the pathologically obese:
Within the context of consolidating services in the health and

social service network, the specific needs of people who are pathologically obese must be adequately met.

Although measures concerning the pathologically obese are dealt with in the continuum of services for people with physical impairments, they concern services provided by all the institutions in the network.

Problems:

- People who are pathologically obese are generally little known in the institutions in the network and are often marginalized;
- For several years now, the "centre de distribution des aides techniques" (technical aids distribution centre) for obese handicapped people, with a mandate to purchase, adapt or create equipment responding to the specific needs of people who are pathologically obese, supplies certain services which should be provided by the network institutions, but which are not available;
- Although, in the past, we have seen a great deal of development in home-care services, those provided by the centre de distribution des aides techniques for this clientele, mainly targeted acute-care hospitals.

Objective:

Our objective is to ensure that this clientele receives care and services adapted to their condition, no matter where they are located, particularly in general and specialized care hospitals or in the home.

So, to ensure that people who suffer from pathological obesity can receive the care and services to which they are entitled, we propose the following measure:

3.3.8 Allocate a development budget of $75,000 to the "Centre de distribution des aides techniques/C.D.A.T" (technical aids distribution centre) to diversify and increase the services it provides

We will be continuing efforts to ensure that general and specialized care hospitals and particularly the CLSCs are informed about the problems faced by the pathologically obese in order to ensure an adequate response to their needs. The following measure is therefore proposed:

3.3.9 Offer information and training sessions if necessary to the general and specialized hospitals and to the CLSCs in collaboration with the organization devoted to this clientele.

3.4 CONTINUUM OF MENTAL HEALTH SERVICES

SOLUTIONS FOR THE FUTURE IN MENTAL HEALTH

3.4.1 Improve integration and re-entry into the community
3.4.2 Continue to develop basic mental health services
3.4.3 Optimize the use of psychiatric hospitalization
3.4.4 Establish a regional suicide prevention plan
3.4.5 Improve access to mental health services for youth
3.4.6 Increase information and awareness-raising among the population

History:

- In 1989, the Department announced its Mental Health Policy;
- In 1990, our region adopted its first regional service organization plan. The two priorities were: to improve the coordination of services and to develop the range of services, particularly those related to rehabilitation and social reintegration;
- In 1995, the Régie régionale prepared its Three-year Plan to transform the health and social service network. The central point was attaining a new balance. As the Plan came to its conclusion, it became evident that the problem related to the continuity and accessibility of certain services had not yet been solved;
- In the spring of 1997, the Ministère de la Santé et des Services sociaux launched its consultation on orientations to transform mental health services. In August 1997, the Régie régionale held a regional consultation on these same orientations.
- In March, 1998, the Régie régionale held hearings on its Plan to improve services for 1998-2002, Accent on Access.

"Orientations to transform mental health services" proposed by the Ministère de la Santé et des Services sociaux

Following the consultations held in the summer of 1997 on the Department's orientations, it became clear to the Régie régionale that the Department's proposal to transform mental health services would have a considerable impact on the organization of services in the region by significantly reducing the rate of acute and long-term beds and initiating an extensive development of services and living environments in the community. A reallocation of resources of close to $76M would be necessary, 90% of which would be used to develop services in the community. Consequently, such a process requires the implementation of facilitating conditions without

which the Régie régionale cannot engage the region in implementing such orientations.

In its Plan to improve services for 1998-2001, *Accent on access*, submitted to hearings in March 1998, the Régie régionale takes a position and proposes the following conditions for performance:

- The formal adoption of Departmental orientations accompanied by measures ensuring the presence of the conditions necessary for success;
- A transition budget of $15M, authorized by the Department, to initiate development of community-based services and the adjustment of human resources, before implementing the social reintegration of the many people hospitalized in long-term facilities and closing a significant number of acute and long-term psychiatric beds;
- Development of residential services in substitute environments, priority rehabilitation-social reintegration services and support for families and relatives;
- The participation of the partners in the region in the regional plan and its implementation according to the timetable retained in order to ensure harmonization of the activities of each component, indispensable to the transfer of resources and clientele to new services, at the right time and in full;
- A five-year schedule, following adoption of the Departmental orientations;
- Mechanisms to increase the involvement of general practitioners in the field of mental health and to improve linkages with psychiatrists.

A more detailed reorganization and transformation project will be developed and presented as soon as the essential conditions have been set in place. For the moment, the Régie régionale is approaching the Plan for 1998-2002 from the point of view of consolidation and improvement of certain elements in the mental health service continuum.

The Plan for 1998-2002 maintains continuity with the Plan for 1995-1998 in that investments made from 1995-1998 are, as you will recall, recurring. This means that community organizations in the field of mental health will continue to receive the amount of $7.3M assigned at that time. Additional amounts of $1.5M for promotion and prevention, of which $0.9M will be allocated to community organizations, as well as $0.3M for support to families will also continue to be paid on a recurring basis.

The results objectives of the Plan cover the first three years, from 1998-2001. Those for the year 2002 will be drawn up as soon as we are informed of the details of the Departmental orientations.

Principal points raised during the consultation:

- The position of the Régie régionale in regard to Departmental orientations (referred to above) was supported;
- The Régie régionale was strongly urged by a large majority of the partners to exercise an energetic leadership in regard to this transformation;
- Action priorities specific to mental health were generally well received: there was consensus in regard to target clienteles and the action strategy to deal with suicide was very favorably received, as was the establishment of a service quality assessment mechanism;
- The principle of telephone access 24 hours/7 days was favorably received but must be re-evaluated in regard to the nature of the information vehicle, possible duplications, potential users and its funding;
- The methodology used to calculate the number of hospital beds was questioned;
- The funding strategy involving the transformation of 120 acute-care beds was also queried; several participants emphasized the necessity for prioritizing clientele with severe and persistent disorders who have spent several years in psychiatric hospitals; the Régie régionale was questioned in regard to bed reductions and funding of its plan;
- The latest expertise in psychiatric institutions must be preserved and developed, the contribution of general and specialized hospitals must be recognized and regional and provincial services must be identified;
- The social integration process for people suffering from severe and persistent mental disorders must enable them to be provided a residential environment, adapted services and rewarding activities and also enable the distribution of services to be improved in the territory;
- Rehabilitation and social reintegration services must be established in the community before returning hospitalized beneficiaries to the community;
- Community organizations active in mental health referred to their contribution and role as significant partners in mental health but deplored the quasi-silence of the Régie régionale in regard to their contribution as essential collaborators in the network of mental health services;
- A close collaboration must be developed with the other service continuums in regard to clientele who require interventions in more than one sector of activity;
- An important point was raised: the lack of a mobilizing youth project for the region. This project must be retained as a priority for the Régie régionale and integrate the organization of child psychiatry services.

PRIORITY CLIENTELES AND MEANS OF ACTION

The plan of action for mental health raises three major issues:
- choice of priority clientele;
- funding of the plan of action;
- management of the reduction of psychiatric hospital beds.

Choice of priority clientele

Priority clientele are an element in the development of new practices and philosophies in mental health and are composed of people who have severe, persistent, or transitory disorders.

The consultation enabled us to validate the choice of this clientele. We believe it is justified to modify our funding strategy by proposing to reallocate the resources currently assigned to these clienteles within the psychiatric hospitals.

This choice of priority clientele is in harmony with the choice made by the Department in the orientations presented in the spring of 1997. It was also confirmed during our regional consultation on these orientations held in the autumn of 1997 and re-affirmed during the public hearings held by the Régie régionale last March. This plan of action reaches the clientele prioritized by the ministère de la Santé et des Services sociaux but also includes clientele suffering from severe and transitory disorders. Our plan of action therefore meets the challenge launched by the Régie régionale, placing the accent on access.

Funding for the plan of action:

Funding of our plan of action is based on the closing of 350 long-term care beds in psychiatric hospitals. This funding represents the following:
- moving of 350 users hospitalized in long-term care;
- since the cost of a long-term care hospital bed is $50,000, we have therefore released funds of around $17.5M (see table 21).

The financing plan is based on the following elements:
- The number of deaths on an annual basis is around 15 to 20 people; for the Plan to improve services from 1998-2002, we retain a figure for natural attrition of 50 places;
- On an annual basis, 50 to 80 people are transferred to regular beds and programs in residential and long-term care centres; for the Plan to improve services for 1998-2002, we estimate that a minimum of 150 people will be transferred in this manner;
- During the past few years, institutions have initiated a movement to reintegrate clientele who have been hospitalized for more than six months, into the community. This movement results in the re-entry of at least 130 people into the community. This number corresponds to the pace that the Régie régionale identified for the 1995-1998 period. For the Plan to improve services for 1998-2002, while being part of the movement already initiated by psychiatric hospitals, we anticipate the reintegration of 150 people.

Taking all these elements into account, for our Plan to improve services for 1998-2002, we anticipate that a minimum of 350 people will be reintegrated into the community. Accordingly, our plan of action is based on this estimate. Funding for our plan of action can therefore be considered as follows: 350 people, for whom the occupation cost per bed is $50,000, enables a total budget of $17.5M to be released. The table presenting funding methods for our plan of action includes a breakdown of the financing sources, movement of users and reallocation methods.

The originality of the financing of our plan of action is that it is based on resources released by natural attrition and the transfer of people experiencing a loss of autonomy to regular residential and long-term care centre programs. This enables these resources to be reinvested in the community to support adults and the elderly in need of mental health services in their living environment, that is basic services and reintegration services. In addition, we will support the residential and long-term care centres in order that they develop programs adapted to serve clientele experiencing a loss of autonomy and in need of the appropriate services adapted to their mental health problems.

Lastly, we will develop a regional admissions' system for long-term hospitalization and permanent placement (family-type and intermediate resources, pavilions). This will improve access to services in the community and to long-term hospital treatment for people in the community and those hospitalized in acute or long-term care, depending on their needs.

Table 20 - SOURCE OF ALLOCATIONS

BEDS MADE AVAILABLE THROUGH LONG-TERMS BEDS IN PSYCHIATRIC HOSPITALS	Number of beds	Margin released
• Natural attrition	50	$2.5M
• People experiencing a loss of autonomy	150	$7.5M
• People in the social reintegration process	150	$7.5M
TOTAL	350 BEDS	$17.5M

Management of the reduction of psychiatric hospital beds:

Between 1995 and 1998, hospitals closed psychiatric beds. Some did so in accordance with the 1995-1998 Reorganization Plan while others took the initiative to introduce closings because of financial cuts and/or to make reallocations to fund their ambulatory services.

Acute-care hospitalization:

In the consultation paper, *Accent on access*, submitted to the public hearings, the Régie régionale proposed closing 120 acute-care psychiatric beds for the 1998-2001 period. The total beds listed in acute-care was estimated at 804 beds in March, 1998, in accordance with the results objectives of the Reorganization Plan for 1995-1998. This closing targeted two hospitals, in view of the fact that their bed-rates per 1,000 inhabitants were the highest in the region and that the resources this would liberate would have permitted significant reallocations.

In addition, during the past year, certain hospitals closed more beds than those provided for in the 1995-1998 plan, in particular the Douglas. Consequently, the revised situation in March 1998 indicated that there are now 706 beds in acute-care psychiatry in the region.

Table 21 - REALLOCATIONS

	Number of people	Cost		REALLOCATIONS 1998	1999	2000
Measure 3.4.1: Improve integration and re-entry into the community						
- Services and resources in the community	180	$9.0M	15	$1.8M	$3.6M	$3.6M
- Adapted places in CHSLDs	60	$1.2M	16	$0.6M	$0.6M	-
- Regular places in CHSLDs	150	-	17			
SUB-TOTAL	**390**	**$10.2M**				
Measure 3.4.2: Continue to develop basic mental health services						
- 24/7 telephone access		$1.0M		-	$0.5M	$0.5M
- Basic mental health services - CLSC		$3.3M		$1.0M	$2.3M	-
SUB-TOTAL		**$4.3M**				
Measure 3.4.3: Optimize the use of psychiatric hospitalization						
(initiate the regional long-term program)	no. of beds					
- Enhancement of long-term beds in psychiatric hospitals	50 beds	$1.2M	18	-	$0.6M	$0.6M
- Creation of regional long-term beds (psychiatric hospitals)	25 beds	$1.8M	19	$1.8M	-	-
SUB-TOTAL	**75 beds**	**$3.0M**				
Measure 3.4.4: Establish a regional suicide prevention plan		-	20			
Measure 3.4.5: Improve mental health services for youth		-	20			
Measure 3.4.6: Increase information and awareness-raising among the population		$1.2M Non recurring				
GRAND TOTAL		**$17.5M**		**$5.2M**	**$7.6M**	**$4.7M**

15 Unit cost/place: $50,000.
16 Enhancement of $20,000 / place
17 From the CHSLDs' budgets
18 Unit bed enhancement cost: $22,000.
19 Unit bed cost: $72,000.
20 Using existing resources

In mental health, the organization of services requires a balance between access to services in the community and to hospitalization services. Consequently, it is imperative that the planning of bed-reductions is drawn up in a coherent manner and within a regional perspective.

Our plan of action specifies a minimum regional standard to be attained for acute-care hospitalization in order to ensure a balance between acute-care hospitalization services and services to be provided in the community during the next three years: **the regional standard to be attained is 0.35 equivalent bed days/presence/year, with a 95% occupation rate at the end of the plan, corresponding to a transformation of 138 acute-care beds.**

The resources liberated by closing beds in hospitals must be reinvested in ambulatory psychiatric services, after approval of their plans by the Régie régionale. This bed standard will be used by the Régie régionale in recommending the issue of institutions' permits. It will also be used as a reference for all work involved in this area.

Therefore, the development in numbers and rates of acute-care beds per 1,000 adults in the region (excluding provincial beds in the Institut philippe Pinel) will be as follows:

Table 22

	March 1995	March 1998	March 2001	March 2002
Number od beds	1,060	706	588	420
Rate/1000 adults	0.63	0.42	0.35	0.25
Notes	According to Régie's data	According to Régie's (revised) data	According to the regional standard of the present plan	According to the standard of orientation (to be confir.) of the MSSS

The Régie régionale will specify how this regional standard will be applied concretely for each of the institutions. **Any procedure proposed by an institution which does not respect the standard which it has been assigned, must be authorized by the Régie régionale in advance.**

Long-term hospitalization

Currently, approximately 1,600 people have been hospitalized for more than six months in Hôpital Louis-H. Lafontaine, Hôpital Rivière-des-Prairies and the Douglas Hospital. Of this number, approximately 25% come from other regions. The service needs of these people vary a great deal. Certain people could be integrated into different living environments in the community or substitute living environments of the residential and long-term care centre type, in regular programs or with programs of services adapted to their needs. For others, the ultimate measure of long-term hospitalization is necessary due to the persistance, complexity and degree of severity of their disease.

In this manner, taking into account the diversity and the different nature of the needs of users currently hospitalized for more than six months in the psychiatric hospitals, it would be hazardous, if not meaningless, to specify the actual rate (per 1,000 adults) of active long-term psychiatric treatment beds.

To remedy this situation, the plan of action proposes the following:

- With the partners' participation, preparation of a reference model for active long-term hospital services including identification of a regional standard for long-term active psychiatric treatment beds;
- Revision of the situation of the 1,600 people and preparation of an orientation plan;
- A decrease in the number of long-term beds in psychiatric hospitals with the closing of 350 beds (released through natural attrition due to deaths, transfers to residential and long-term care centres and re-entry of people into the community);
- Enhancement of 75 long-term hospital beds
- Establishment of a regional admissions' system for long-term hospitalization accessible to people hospitalized in psychiatric and general and specialized care hospitals.

Any initiative proposed by an institution which does not respect this process will inevitably result in the Régie régionale withholding its support for such initiative. In addition, any requests for authorization involved in these initiatives concerning human, financial, material and fixed-asset resources cannot be sanctioned by the Régie régionale. Reallocation movements must be performed within the perspective of the psychiatric hospitals' budgetary realities and targets set in the budgetary balancing plan.

3.4.1 Improve integration and re-entry into the community

Objective

Ensure access to quality mental health services in the community for anyone suffering from severe, transitory or

persistent mental disorders, particularly those living in the community and those living in a hospital environment who are to be reintegrated into the community.

Results targeted

For all clientele

- Quality control program in public and private residential resources;
- Regional admissions' system for permanent placement (family-type and intermediate resources and pavilions);
- Equity of access between the sub-regions, of residential resources and services providing rehabilitation and social reintegration into the community, whether they be under the jurisdiction of an institution or a community organization;
- Equity of access and diversity of ambulatory psychiatric services: out-patient clinics, day hospital, intensive psychiatric follow-up, etc.;
- On completion of the plan, increase in the rate of users served by ambulatory services versus a hospitalization to an average of 90% (the average rate was 83.6% during 1996-1997);
- Formal liaison mechanisms between first-line mental health services and hospital services;
- Results monitoring system.

For clientele hospitalized for more than 6 months

- Revise the situation of approximately 1,600 people and prepare a regional orientation plan;
- Reintegrate 390 people in residential and long-term care centres and in residential resources located, as a priority, in the least affluent sub-regions (West, Centre-West, Centre-East and North) with access to other rehabilitation and social reintegration services which they need;
- Manpower training and adjustment activities, as part of the regional training plan;
- Results monitoring system.

Funding:

Funding of this measure will be provided through reallocations of $10.2M, of which $1.2M will be paid to residential and long-term care centres for the adapted program and $9M to other resources in the community.

3.4.2 Continue to develop basic mental health services

Objective:

- Facilitate access to basic services in the community in order to prevent the deterioration of the health and welfare of persons suffering from transitory or persistent mental disorders as well as their families and relatives.

Results targeted:

- Increase the number of basic mental-health medical acts in CLSCs and private clinics;
- Formal liaison mechanisms on a local basis of partners working in the field of basic mental-health services: users' self-help groups, family groups, crisis intervention centres, CLSCs, medical clinics, professional practices, etc.;
- 24 hour/7 day telephone access to mental health information and referral services (the concept of service must be up-dated, provider(s) identified and the impacts, interfaces and clientele for other providers including the CLSCs and other telephone listening services specified, etc.);
- Increase the number of clients benefiting from basic mental health services in CLSCs, particularly for services involving reception, assessment, referrals and brief interventions;
- Manpower training and adjustment activities, as part of the regional training plan;
- Results monitoring system.

Funding:

Funding of this measure will be provided by reallocations of $4.3M, of which $1M will be used to establish access to a 24 hour/7 day telephone service and $3.3M assigned to basic mental-health services in the CLSCs.

3.4.3 Optimize the use of psychiatric hospitalization

Objective

- When required, ensure that people suffering from severe, transitory or persistent mental disorders have access to acute-care psychiatric hospitalization services with a return to the community as soon as the person's conditions warrants.

Results targeted:

- Eliminate stays of more than 48 hours in emergency rooms;
- Reduce the average length of acute-care hospitalization stays to 20 days;
- Attain the standard of 0.35 bed days/presence/acute-care hospitalization per 1,000 inhabitants (maintain 588 beds) by transforming 118 acute-care beds into ambulatory services;
- Regional admissions' system for long-term hospitalization in psychiatric hospitals;
- Reference model for the regional hospitalization program;
- Definition of mandates and responsibilities in regard to

acute-care and long-term hospitalization services at the sub-regional, regional and provincial levels;
- Closing of 350 long-term psychiatric hospital beds;
- Opening of 25 beds and enhancement of 50 regional long-term hospitalization beds
- Manpower training and adjustment activities, as part of the regional training plan;
- Results monitoring system.

Funding:
Funding of this measure will be provided by reallocations of $3M, of which $1.2M will be used to enhance long-term beds and $1.8M to create regional long-term beds in psychiatric hospitals.

3.4.4 Establish a regional suicide prevention plan

Objective:
Stabilize, if not decrease, the rate of mortality by suicide for clientele at risk according to the health and social survey performed in 1992-1993.

Results targeted:
- Regional plan to implement the Stratégie québécoise d'actions face au suicide (Quebec action strategy against suicide);
- Media communications plan;
- Stabilization or decrease in the annual average rate of hospitalization for suicide attempts (regional average 1993-1996: 563 hospitalizations per year);
- Stabilization or decrease in the rate of mortality by suicide (regional rate for 1993-1995: 14.7 / 100,000 inhabitants.

Funding:
Funding of this measure will be performed through already existing resources.

3.4.5 Improve access to mental health services for youth

Objective:
- Ensure access to child psychiatry services to children and youth with mental health problems as well as those whose parents are suffering from mental health problems.

Results targeted:
- Definition of mandates and responsibilities for ambulatory services as well as for hospitalization;
- Harmonization of sectorization in child psychiatry with adult mental health sectorization;
- Formal liaison mechanisms with partners intervening with children and youth at the level of basic mental health services.

Funding:
Funding of this measure will be provided through already existing resources.

3.4.6 Increase information and awareness-raising among the population

Objectives:
- Work against intolerance and prejudice toward mental health problems and mental illness;
- Verify the impact of the Plan to improve services on the health and welfare of the population.

Results targeted:
- Understanding of mental health problems and mental illness;
- Positive perception of the individual's potential;
- Information on the mental health service network;
- Screening of high risk situations;
- Understanding of the impact of the organization of services on the state of health and welfare of the population

Funding:
Funding of this measure will be provided by a non-recurring budget of $1.2M.

3.5 CONTINUUM OF SERVICES FOR PEOPLE WITH INTELLECTUAL IMPAIRMENTS

SOLUTIONS FOR THE FUTURE FOR PEOPLE WITH INTELLECTUAL IMPAIRMENTS

3.5.1 Inject a budget of $12M to provide a response to a portion of the people waiting for services
3.5.2 Transform residential and socio-occupational services
3.5.3 Establish an integrated service network for autistic people and those suffering from pervasive developmental disorders
3.5.4 Develop individual or overall agreements between intellectual impairment rehabilitation centres to ensure access to services for the English-speaking population
3.5.5 Prepare agreements with the partners concerned to ensure access for clientele with special needs.

The following proposal constitutes the regional service organization plan for people with intellectual impairments for the years 1998-2002.

Principles of the regional service organization plan:
The service organization plan for people with intellectual impairments is based on a number of principles considered essential to any action designed to improve access to services and increase their quality. These principles are:

- The integration of people with an intellectual impairment into the community continues to be a human and social imperative
- The person with an intellectual impairment, his/her family and relatives are the focal point of all decisions concerning them. They participate actively in all decision-making processes concerning the organization of their services;
- Social role valorization and the quality of life of the persons, their families or relatives, must be an integral part of all choices in organizing services.

Intellectual impairment rehabilitation centres have developed a specialized approach toward people with an intellectual impairment. In order to preserve this expertise, the centres must be consolidated and consequently, no transfer of resources shall be made to other institutions.

Roles of the various service providers
Intellectual impairment rehabilitation centres have developed the latest expertise in regard to persons with an intellectual impairment. They have perfected orientations concerning, among others, social role valorization, management by program in a personalized approach, as well as the provision of services in a community integration context.

The Régie régionale recognizes that intellectual impairment rehabilitation centres play a central role for these people. The centres are:

- responsible for ensuring the provision of services for people with an intellectual impairment as well as those with associated problems (multiple impairments, loss of autonomy, mental health, justice, pervasive developmental disorders);
- responsible for the overall assessment of needs as well as the provision of adaptation, rehabilitation and social reintegration services according to the specific needs of these people, as well as services providing accompaniment and support to their friends and families.

The service access coordination mechanism confirms the role of the CLSCs as principal gate of entry to the network of services for people with intellectual impairments. In addition to the summary assessment of needs for services and the management of the family support program, they offer all routine health and social services.

However, the range of services necessary to respond to the multiple needs of these individuals cannot be assumed uniquely by these two types of institutions. The contribution of other partners in providing services, according to their mandates and specific expertise, is essential in order to guarantee a continuum of services. Among others, we refer to the complementary role of:

- residential and long-term care centres in services involving placement, assistance, support and rehabilitation for clientele experiencing a loss of autonomy;
- psychiatric hospitals in terms of specialized psychosocial rehabilitation services, and preventive services for clientele with problems related to mental health;
- physical impairment rehabilitation centres for adaptation, rehabilitation and social integration services for people with physical impairments as well as accompaniment and support services for their friends and relatives;
- community organizations for prevention, assistance and support services including temporary placement services, promotion activities awareness-raising, defense of rights and social development of people in the region.

Service planning:
This service organization plan focuses on the accessibility, adequacy and diversity of services. In spite of the development of support services in the community, the fundamental problem still has not yet been solved and there is a basic lack

of balance in the continuum of services for people with intellectual impairments, in that:

- many people are still without any services;
- a large number of beneficiairies receive services in one program, but are awaiting other services;
- access waiting periods are too long;
- resources are concentrated in residential programs in institutions and there are insufficient resources in socio-occupational programs and support for the person, the family and the community;
- the increase in the number of people with intellectual impairments in the regional population is estimated at 0.3% per year, indicating a low growth rate of new people in need of services.

Principal points raised in the consultation:

Notices submitted during the Régie régionale's consultation have been used to orient our current service organization plan. In general, these notices indicated:

- general satisfaction that intellectual impairment is considered a priority and that $12M will be injected to offer services to this clientele;
- that the objective to eliminate waiting lists was unanimously approved, but with the following considerations:
  - confidence must be shown in institutions which will take the measures necessary to absorb waiting lists (allow them to choose the means);
  - waiting lists are different in each territory;
  - the data contained in the plan must be validated;
  - the rate of increase on waiting lists must be calculated;
  - A follow-up mechanism must be established to ensure objectives are attained.
- In regard to the transformation of services, the following considerations must be taken into account:
  - a range of residential resources must be preserved;
  - a mechanism to control and improve the quality of residential services must be established.
- Users' committees fear that the changes will result in a loss of their personal liberty;
- Staff skills must be maintained;
- Several groups call for a regional service organization plan in order to clarify the roles and mandates of the institutions in the network and their partners;
- Hypothesis 1 must be retained: the centres must conclude inter-institution agreements in order to offer quality services to their English-speaking users.
- The concept of lifestyle is ambiguous and must be clarified;
- The budget injected in the CLSCs to provide family support services must be reserved for intellectual impairment;
- Emphasis must be placed on prevention and intervention. It is imperative that investments be made in early stimulation. Rapid access to services must be guaranteed.
- In regard to autism:
  - leadership in serving this clientele must be clarified;
  - an integrated network of services must be established;
- Participants in associated fields recommend avoiding the use of long-term psychiatric care.

Objectives:

Our service organization plan for the years 1998-2002 will therefore pursue the following objectives:

- By 2002, serve all people waiting for residential and socio-occupational services and support services for the person, the family and the community;
- Improve access to services designed for autistic people and those suffering from pervasive developmental disorders;
- Ensure access to services for the English-speaking population;
- Ensure access to services for clientele with special needs.

Based on these premises, our service organization plan is designed, through concrete and targeted measures, to permanently resolve problems which, for many years, have seriously affected the accessibility of all services. This lack of access to services is a major factor contributing to the deterioration of the state of the clientele's health, both physical and mental, alterations in their living conditions and the increase in the confusion and dismay of their families.

The range of services:

The range of services for people with intellectual impairments is primarily based on three main programs. These programs provide residential and socio-occupational services as well as support for the person, the family and the community.

We will also deal more specifically with the organization of services designed for autistic people and those suffering from pervasive developmental disorders.

■ Residential program:[21]

Our service organization plan includes four specific elements related to the residential program:

1. The possible transfer of 103 people to residential and long-term care centres. This transfer is conditional on the agreement of the person and his/her family and the assessment of his/her needs. In order to ensure

[21] The figures quoted are guides. They will be validated following the submission of the institutions' plans of action.

personalized and high quality services for people to be transferred to residential and long-term care centres, during 1998, we will be performing a pilot project to assess the specific needs of these people and the type of activities to be organized to meet them.

2. Seventy-eight places will be maintained in "Internats" (residential facilities). Considering the complex and intense needs of certain people, as well as the importance of properly designing and introducing the type of resources appropriate for these users. It seems more prudent, for the moment, to retain a certain number of places in this type of facility.
3. Four hundred and forty-five places will be opened in family-type and intermediate resources, that is 165 places to serve people transferred from Internat facilities, group homes and community residences and 280 places to receive people on the waiting list. This measure will require a mechanism to ensure the quality of services.
4. A specialized support service will be created or consolidated in family environments. This service, which will serve 100 people on the waiting list for residential services, is designed to assist the person in performing various daily life activities. This could include assistance in getting up and going to bed, accompaniment for various outings, or civic support activities.

All developments in the transformation of residential resources will be performed according to the following conditions:

- The needs of the person must be the primary decision-making criteria;
- The agreement of the person, his/her family or relatives is an essential condition for any transfer to any resource whatsoever;
- The creation of a vigilance committee with a mandate to participate in drawing up specific eligibility criteria, following up operations and evaluating the pilot project concerning the transfer of certain people to residential and long-term care centres;
- The introduction of a service quality control mechanism for family-type and intermediate resources;
- The adaptability of living environments to the particular needs of people with an intellectual impairment;
- The formal support and commitment of the intellectual impairment rehabilitation centres in regard to training and follow-up of each person transferred and for as long as is necessary.

■ Socio-occupational program:[22]

Our service organization plan is designed to serve 439 people awaiting a socio-occupational service. To this end, we will:

- inject a budget of $3M which will enable 300 people on the waiting list to be served by opening new places in diversified socio-occupational services;
- transform socio-occupational services to enable 139 people on the waiting list to be served, by offering a support service for community activities. This service involves giving the person the opportunity to carry out the activities he/she chooses and which are socially valorizing. These activities may be recreational, sports, cultural or educational. This service takes the form of accompaniment.

■ Program providing support to the person, the family and the community[23]:

In this last program, we will develop two ranges of services: adaptation and support for the person, the family and relatives for which the intellectual impairment rehabilitation centres will take responsibility and family support services for which the CLSC will be responsible.

- **Adaptation and support services for the person, the family and relatives (CRPDI - rehabilitation centre for persons with an intellectual impairment)**
  Our service organization plan will enable 500 people on the waiting list to be served. These services are designed to develop and maintain the person's autonomy so that he/she may be integrated or maintained in the natural or substitute living environment, in a day-care centre or school and in the community. It is also designed to enable the person's relatives to intervene in these areas. These services include early stimulation programs for infants from 0 to 5 years. To this end, we propose:
  - using personnel released by the transformation of services;
  - increasing the intensity of the educational support service for children to a minimum of 2.5 hours/week and, ideally, to even more, up to 4 or 5 hours/week.

- **CLSC services offering support to the family:**
  A budget of $2.3M is assigned specifically for the program offering support for the family managed by the 29 CLSCs in the region. The data presented only concern services designed for people with an intellectual impairment. The continuum of services for

[22] The figures quoted are guides. They will be validated following the submission of the institutions' plans of action.

[23] The figures quoted are guides. They will be validated following the submission of the institutions' plans of action.

people with physical impairments will announce a similar measure for its clientele.

According to our calculations, as at March, 1998, there will be 271 families waiting for services involving the family support program. Considering the increase in requests of 162 families per year, we plan to inject a budget of $2.3M to provide services to the 757 families anticipated by the year 2002 and to increase subsidies when required

Solutions for the future:

Attaining our objectives requires the introduction of five distinct measures:

1. The injection of a budget of $12M[24];
2. The transformation of residential and socio-occupational services for the equivalent of a level of resources similar to measure 1;
3. The implementation of an integrated service network for autistic people and those with pervasive developmental disorders;
4. The development of individual or overall agreements between the intellectual impairment rehabilitation centres to ensure access to services for English-speaking people;
5. The preparation of agreements with the partners concerned to ensure access for clienteles with special needs.

As at March 31, 1998, a breakdown of the waiting lists indicated that:

- For services in intellectual impairment rehabilitation centres:
  - 622 different people were waiting for services, while receiving none at all;
  - 470 different people were receiving at least one service but were waiting for other services.
  This means that a total of 1,092 different people were waiting for 1,319 services.

- For CLSC family support services:
  - 271 different people were waiting for services.
  Note that an estimate of requests for services establishes the number of people to be served by the year 2002 at 757.

- In order to respond to waiting lists for both types of institution, our plan is designed to make 2,076 services available (1,319 + 757).

[24] For the first two measures, the breakdown of resources to be injected or transformed will be validated following the analysis of plans of action submitted by the institutions and accepted by the Régie régionale.

Number of people on the waiting list for the three intellectual impairment programs, per program, over a three year period:

Table 23

Program	Number of people on the waiting list as at March 31, 1998[25]
Residential	380 persons
Socio-occupational	439 persons
Support to the person, the family and the community	
- Rehabilitation centres.	500 persons
- CLSCs	271 persons
Total	**1,590 pers./service[26]**

The data in the figures and tables in points 3.5.1 and 3.5.2 are provided as a guide and will be validated during work which the institutions will be required to perform. The Régie régionale will ask the institutions to submit:

1- A situation report covering:
   - waiting lists
   - services provided according to organizations users/resources
2- A financial report: this report will identify the costs per type of service.
3- A plan of action: This plan of action will identify the measures proposed by each institution to resolve its waiting lists using its own resources and by adding resources if necessary to maximize existing resources, since the institutions are responsible and accountable for the services to be provided to their clienteles. The plans of action will be submitted by the institutions two months after adoption of Accent on access and must be accepted by the Régie régionale.

3.5.1 Inject a budget of $12M to provide a response to a portion of the people waiting for services

The injection of a budget of $12M will enable services to be provided to a portion of the people on the waiting list.

[25] This data must be validated by the statistical report which will be submitted by the institutions shortly.

[26] Considering that the estimate concerning the increase in the CLSCs' family support services indicates that there will be 757 families to be served by the year 2002. A total number of person/services for all programs is therefore 2,076 for the period of our plan.

Table 24

	Persons served on the waiting list	Persons remaining on the waiting list
Invest $5.8M in residential services	280 persons	100 persons
Invest $3M in socio-occupational services	300 persons	139 persons
Services providing support to the person, the family and the community		
- Rehabilitation centres	0 families	500 persons
- CLSCs		
• Invest $2.3M family support services	757 families	0 families
Invest $0.9M in specialized services for people with pervasive developmental disorders	n.a.	n.a.
Total : $12M	**1,337 person/services**	**739 person/services**

3.3.2 Transform residential and socio-occupational services

The transformation of residential services illustrated in the following tables, indicates the services and resources affected.

Transformation of residential services

Table 25

Nature of the service Measure	Current number of places	Number of places less	Remaining number of places in 2002
Decrease places in internat facilities	181	103	78
Close places in group homes	44	44	0
Reduce the number of places in community residences	842	121	721
Total	**1,067**	**268**	**799**

This transformation of residential services will enable 236.66 equivalent full-time (E.F.T.) positions to be liberated. All the personnel will be redeployed to other services.

Personnel affected by the transformation:

Table 26

Categories	Positions (E.F.T)
Educators	50.4
Orderlies	160.66
Nursing assistants	2.5
Nurses	10.12
Professionals	4.77
Management personnel	8.21
Total	**236.66**

The 739 person/services remaining on the waiting list following the development budget will be served by human and financial resources equal to $11.8M liberated by the transformation of services.

Impact of the transformation of services on waiting lists

(see table 27 at right)

3.3.3 Establish an integrated service network for autistic people and those suffering from pervasive developmental disorders

The budget assigned to this measure is $0.9M[27].

Work already performed has helped to clarify the state of the resources and needs of autistic people. Among others, we note several deficiencies which must be filled, particularly in regard to assessment and rehabilitation services and in services providing support to the family and relatives.

[27] As a guide.

Table 27

Development of services	Persons on the waiting list served	Persons remaining on the waiting list
Specialized services providing support in family environments	100 persons (from the waiting list for residential services)	0 persons
Diversified socio-occupational services	139 persons	0 persons
Services for the person, the family and the community - Rehabilitation hospitals	500 persons	0 persons
Total	**739 persons**	**0 persons**

The report on various studies concerning prevalence rates carried out by Diane Brassard[28], concluded that between 4 and 10 people in 10,000 suffer from autism. This means there are between 850 and 1,850 autistic people in the region. The prevalence rate for people suffering from pervasive developmental disorders varies between 10 and 22 per 10,000 people, which indicates that there are between 1,850 and 4,100 people with pervasive developmental disorders in the region.

In order to ensure effective coordination of services, responsibility must be assigned to one specific player. We intend to explore the possibility of assigning this coordination to an institution in the rehabilitation network. This institution will work in close collaboration with all the other sectors involved including first-line services (screening and support for the family), mental health services (diagnosis and specialized treatment), acute physical care health services (diagnostic assessment and treatment of a medical nature), intellectual impairment rehabilitation services, parents' associations and the schools.

In accordance with Departmental orientations and based on the results obtained during the year of pilot projects oriented toward all service components, in 1998 we will implement the integrated service network for autistic people, their families and relatives.

3.5.4 Develop individual or overall agreements between intellectual impairment rehabilitation centres to ensure access to services for the English-speaking population

Each intellectual impairment rehabilitation centre is responsible for providing services to the English-speaking population, in accordance with the territorial approach. The centres must conclude inter-institution agreements to offer quality services to their English-speaking population.

These agreements cover two levels: overall agreements between institutions and individualized agreements for each person targeted.

In order to follow the accomplishment of this objective, we will be including a specific accountability feature, according to which institutions must account for the satisfaction of the clientele affected by these overall or individualized agreements.

Summary:

- Each rehabilitation centre is responsible for providing services to the English-speaking and ethno-cultural populations in its territory, determined according to geographical boundaries;
- The designation of the Promotions sociales Taylor-Thibodeau must be maintained for Internat facility services for English-speaking people, with the exception of people residing in the territory of the Miriam Centre;
- Institutions must conclude overall or individualized agreements in order to fulfill their responsibilities or must have recourse to the regional bank of interpreters in order to provide better services for the allophone population;
- Each institution is responsible and accountable for the population in its territory.

3.5.5 Prepare agreements with the partners concerned to ensure access for clienteles with special needs

People with multiple impairments:

Some people suffer from both an intellectual impairment and one or more motor or sensory impairments. These individuals encounter two special problems. The first involves access to specialized services. The fact that they have impairments which fall under the jurisdiction of two or three different service networks places responsibility for case management in question. The second problem they encounter concerns the quality of services. In fact, traditional case management goes hand in hand with services that are compartmentalized according to institution. Since the person has complex needs,

[28] Diane Brassard, État de situation des services offerts aux personnes présentant des troubles envahissants du développement (TED) dans la région de Montréal-Centre en 1996-1997, October, 1997.

often some are not taken into account. To remedy these situations, we propose that:

- responsibility for ensuring a response to the needs of people with multiple impairments including an intellectual impairment, be assigned to the intellectual impairment rehabilitation centres;
- an individualized service plan should be prepared for all people who have multiple impairments, employing the contribution of the service networks involved. Services must be dispensed according to the plan by sharing the responsibilities between the networks concerned.
- in the absence of specialized services in the area of family-type or intermediate resources, intellectual impairment rehabilitation centres shall establish agreements with the partners concerned to ensure the person has access to the service.

Persons experiencing other special situations:
For other people who suffer from a variety of problems such as mental health, social adjustment and justice, we propose an approach obliging a sharing of responsibilities between the different service networks concerned.

CONCLUSION:

Implementation of all these measures poses an important challenge to the intellectual impairment rehabilitation centres which, by associating themselves with the families and relatives, as well as with other service providers, will have to produce a plan of action by no later than September 15, 1998, which must be accepted by the Régie régionale

This chapter, together with the institutions' plans of action approved by the Régie régionale will serve as the regional service organization plan for people with an intellectual impairment for 1998-2002.

3.6 CONTINUUM OF SOCIAL ADJUSTMENT SERVICES

This continuum covers five areas:

3.6.1 Services for children, youth, young adults and their parents
3.6.2 Services related to violence against women
3.6.3 Services concerning alcoholism and drug addiction
3.6.4 Services for the homeless
3.6.5 Services concerning AIDS

3.6.1 Services for children, youth, young adults and their parents

SOLUTIONS FOR THE FUTURE FOR CHILDREN, YOUTH, YOUNG ADULTS AND THEIR PARENTS

3.6.1.1 By the year 2002, develop a shared and mobilizing youth project in Montreal designed for youth and their parents
3.6.1.2 As part of the youth project and in keeping with its orientations, develop four specific intervention programs to provide effective action in combating parental negligence, family violence toward children, violence during adolescence, exclusion and marginalization
3.6.1.3 During 1998-2002, employing the same orientations as the priority youth program, intensify prevention/promotion interventions and all forms of interventions performed before the need for services appears
3.6.1.4 Improve access to services in each CLSC territory and on a regional level
3.6.1.5 Introduce coordination and participatory mechanisms in each of the CLSC territories and at the regional level, to reinforce the unity of action of the sectoral and intersectoral players
3.6.1.6 As part of the implementation of the youth project, consolidate and improve the integration of specialized services to support interventions performed close to natural living environments
3.6.1.7 Improve our intersectoral strategies by preparing a breakdown chart to analyze and compare investments, needs and results at a local level.

The plan to reorganize services for 1995-1998 targeted two main areas of action:

- An increase in prevention activities;
- The introduction of an interactive service network.

The first action targeted was, in general, attained. As for the second, several deficiencies remain in the integration of services and achieving united action by the partners.

In its Plan to improve services for 1998-2002, "Solutions for the future for children, youth and young adults as well as their parents"[29], the Régie régionale seeks to consolidate the interactive network by focusing on the development of a youth project for Montreal.

Principal points raised during the consultation:
The measures retained for 1998-2002 and presented hereafter are based on the findings and issues expressed in the consultation paper and validated during the public hearings and the youth forum held on the same occasion. These findings are as follows:

The specificity of the metropolitan socio-economic context:

- Montreal's population of children, youth and young adults have specific characteristics which increase their vulnerability
- Demography: there is a concentration of young English-speaking youth in Montreal (26.5% of the youth population in Montreal) and there are two centres jeunesse, Centres jeunesse de Montréal and the Batshaw Youth and Family Centres which offers services in English by virtue of Article 125 of the Act respecting health services and social services and by virtue of the access program for health and social services in English.
- Montreal's demographic curve shows little variation for the next few years in terms of the 0-5 and 6-17 year-old groups[30].

These demographic elements indicate that it will be necessary to maintain the same level of services and resources during the years to come, in order to respond to the needs of children, no matter to which language group and cultural community they belong.

Poverty:

Close to one youth in three, between 0 and 25 years of age, in Montreal is poor in every age category. This means that around 170,000 youths live in poverty. Fifteen (15) CLSC territories have a poverty rate among youth, 0-25 years of age, of more than 35%; in five of these territories close to half the children are poor

This high rate of poverty among children, youth and young adults generates a high prevalence of problems and serious psychosocial disabilities: low education levels, illiteracy, isolation, psychological distress, exclusion, marginalization, school drop-outs, integration and socialization difficulties, delinquency, violence, etc.

Interventions must therefore give priority to territories defined as being particularly poor.

Multi-ethnicity

The metropolitan character of our region with its high occupation density in certain neighborhoods, is also distinguished by the ethnic diversity of the population. This situation is particularly notable among youth and it creates a great many problems concerning integration and inter-cultural conflicts between groups of young people as well as in families, between parents and children.

For this reason we must devote specific means to adapt interventions to the conditions and values of groups from the cultural communities.

Priority problems to be considered:

- Parental violence against children from 0 to 11 years of age;
- Family violence against very young children (0-5 years) and children (6-11 years);
- Violence among adolescents (12-17 years);
- The exclusion and marginalization of youth and young adults.

A SERVICE PROVISION SYSTEM

- **Assets:**
  - Stronger prevention/promotion interventions;
  - The CLSCs' sustained involvement with "youth and parent" clientele;
  - Stronger interventions rendered on an external basis;
  - Decentralization of the activities of the Centres jeunesse according to the "environment" approach;
  - The involvement of community organizations;

[29] The term "youth and parents" is used throughout this section to refer to "children, youth, young adults as well as their parents".

[30] Source : MSSS, Birth data base, 1986 to 1996.

- **Questions:**
  - The absence of a shared and mobilizing youth project, based on a common vision of realities and needs and focusing on the pursuit of shared objectives;
  - Interventions are still generally performed after the fact, when problems have taken root or become aggravated;
  - The slow pace at which services are developed for youth close to their living environments;
  - Still insufficient place assigned to "family", "community" and "intersectoral" approaches;
  - Marked compartmentalization and a lack of integration of the services offered.

3.6.1.1 *By the year 2002, develop a shared and mobilizing youth project in Montreal designed for youth and their parents*

Guiding principles:

- A plan to improve services for youth and their parents:
  - focusing on the development of a shared and mobilizing youth project in Montreal, by the year 2002, which reaches children and youth in Montreal in all the cultural communities, French-speaking, English-speaking, or other;
  - which, within the scope of integrating preventive and curative interventions, targets identified priority problems;
  - which encourages increasing prevention/promotion interventions or all forms of intervention performed before the need appears;
  - which seeks to reinforce curative or "early" interventions rendered on an external basis and the optimum decentralization of activities performed close to natural living environments
  - which encourages an increase in "family', "community", intersectoral" approaches;
  - Which, while resolutely avoiding any inter-institutional "sharing model" and the transfer of staff such a model would involve, encourages the pursuit of the program to decentralize the activities of the Centres jeunesse in the community and to bring practitioners together in order to improve the continuity of activities;
  - which stresses maximizing the use of the "network approach";
  - which facilitates the development and optimum availability of a more specialized intervention force, exercised in support and complementarity with the intervention force which acts close to natural living environments;
  - which, within a perspective of sustained quality improvement, facilitates reinforcement of regional coordination, evaluation of programs according to targeted results, development of information and management systems and training activities;
  - which counts on the participation and support of the university institute in the field of violence among youth in the Centres jeunesse de Montréal, the Direction de la santé publique and its provincial institute.

Structural elements of the youth project:

- Objectives:
  - To improve the state of health and welfare of youth;
  - The optimum development, adaptation and social integration of youth, particularly those who are most disadvantaged;
  - To improve the conditions of safety and protection for youth and the public in general.

The organizational players:

- The CLSCs and the centres jeunesse:
- All the other players in the health and social service network and, in particular, childrens' hospitals, out-patient clinics, child psychiatry services, physical impairment rehabilitation centres, intellectual impairment rehabilitation centres and rehabilitation centres for alcoholism and drug addiction;
- Various intersectoral partners concerned including schools, custodial facilities, community organizations, municipalities and the police, so that youth can be reached in their own environment.

Services offered and performed:

- within an integrated service continuum;
- on the basis of multisectoral coordination;
- according to a preventive and community approach;
- in the most accessible manner possible, close to natural living environments;
- on an out-patient basis or for admitted cases, if required.

Means of action:

- During 1998-1999, under the Régie régionale's coordination, introduce a structured approach in order to implement a youth project in each of the CLSC territories;
- By December, 1998, present the youth project selected to the Régie régionale (vision of needs, intervention strategies, proposed plans of action including results objectives, follow-up indicators and timetable for performance).

3.6.1.2 *As part of the youth project and in keeping with its orientations, develop four specific intervention programs to provide effective action in combating parental negligence, family violence toward children, violence during adolescence, exclusion and marginalization*

Means of action:

1) To deal with parental negligence toward children from 0 to 11 years of age:
   - Intensify interventions designed to develop parenting skills and food security;
   - Establish effective screening and proactive intervention strategies.
2) To deal with family violence toward children from 0 to 11 years of age:
   - Develop adapted multisectoral interventions in regard to problems concerning physical and sexual abuse;
   - Develop support groups for violent parents.
3) To deal with violence among adolescents (12-17 years) :
   - Develop an overall promotion and prevention plan in regard to targeted territories;
   - Develop and implement intervention strategies focusing on encouraging parental responsibility, providing parents with support and involving the multisectoral forces in the community.
4) To deal with exclusion and marginalization:
   - Develop prevention activities targeting pregnancy and STDs;
   - Establish intra and inter-sectoral intervention programs focusing on the various facets of the problem of exclusion and marginalization, according to the environment being targeted.

For each of these problems, results objectives will be drawn up during the preparation of the youth project and a follow-up on achievement of these objectives will be performed during the periods 1999-200, 2000-2001 and 2001-2002.

3.6.1.3 *During 1998-2002, employing the same orientations as the priority youth program, intensify prevention/promotion interventions and all forms of interventions performed before the need for services appears*

In the plan for 1998-2002, the Régie régionale intends to continue, reinforce and consolidate the investments already made in its territory in regard to prevention/promotion activities for very young children (0-5 years) and youth (6-18 years).

Thus, in continuing to implement regional priorities concerning very young children and youth introduced as part of the many measures in the Plan for 1995-1998, the local youth projects in the Plan for 1998-2002 must, in particular, ensure the consolidation and reinforcement of projects such as "Naître égaux, grandir en santé" for very young children and intersectoral plans of action which focus on the overall development of youth in priority territories.

On the basis of the costs already associated with these projects in the Plan for 1995-1998, we estimate the resources required to consolidate these programs in the 1998-2002 plan at $7M.

Means of action:

- Each youth project prepared on a local basis must, among others, provide for the implementation of prevention/promotion projects of the type "Naître égaux, grandir en santé" and intersectoral plans of action which focus on the overall development of youth in priority territories. The resources necessary to introduce these programs must be released from the resources of the Centres jeunesse and the CLSCs infancy-youth-family programs in the region, on a prorate basis to be determined.
- During the 1999-2000, 2000-2001 and 2001-2002 fiscal periods, the Régie régionale must, if necessary, make reallocations from the already existing youth budgets to make up for the deviation between the percentage of these programs implemented in the territory and their complete coverage in the most vulnerable territories.
- Implementation of the program to decentralize the Centres jeunesse activities in the community during 1998-1999 must be continued as well as the development of new deployment measures, if required, during the 1999-200, 2000-2001 and 2001-2002 periods.
- The results objectives will be established with the partners concerned by December 1998, as part of the preparation of the youth project.

3.6.1.4 *Improve access to services in each CLSC territory and on a regional level*

Means of action:

- Improve the linkage of social emergency intervention systems (Centres jeunesse and other partners) with CLSC services, crisis centres and telephone listening lines.
- Improve the operation of mechanisms which provide access to rehabilitation and family support services in the various service continuums.

3.6.1.5 *Introduce coordination and participatory mechanisms in each of the CLSC territories and at the regional level, to reinforce the unity of action of the sectoral and intersectoral players*

All coordination and participation mechanisms will be developed with the partners by December 1998.

Certain principles or mechanisms have already been proposed:

- Overall coordination to be assumed by the Régie régionale as the youth project's leader and performed with respect for the missions assigned and decision-making levels in place;
- The performance territory for the youth project is the CLSC territory;
- A network approach and the establishment of partnerships which respect the distinctive strengths and contributions of each partner;
- Two participation and coordination mechanisms established at the local level:
  1) Project teams grouping various sectoral and intersectoral partners depending on the problem targeted. Leadership of the project teams will be determined by the partners, depending on the situation;
  2) A territorial coordination mechanism grouping together the various partners concerned.
- Collaboration agreements established between the partners to facilitate performance of interventions;
- Mandates exercised by the Centres jeunesse and the CLSCs on the basis of the missions assigned and distinctive contributions exercised "for the most part" by each party;

Consent established on both sides to make "minor" investments in the exercise of duties for which each is generally less recognized.

3.6.1.6 *As part of the implementation of the youth project, consolidate and improve the integration of specialized services to support interventions performed close to natural living environments*

Intervening close to the natural living environment and the corresponding decentralization of youth sector activities, require specialized and more in-depth expertise and support for the intervention force provided on a local basis by the CLSCs and the Centres jeunesse. For this reason, linkage and collaboration mechanisms must be established between the CLSCs, the Centres jeunesse and the other sectoral partners in the health and social service network: pediatrics, child psychiatry, and the intellectual impairment, alcoholism and drug addiction and physical impairment networks.

3.6.1.7 *Improve our intersectoral strategies by preparing a breakdown chart to analyze and compare investments, needs and results at a local level*

In view of the relative permanence of the effects of the main determining factors on health and welfare, do the organizations responsible for planning interventions to meet the needs of the population select the best strategies? This general question is the background for a proposal to prepare a breakdown chart of the territory to enable an analysis and comparison of investments, needs and results on a local level.

The analysis of youth investments (0-25 years) required in social adjustment services will be our first field of investigation.

Means of action:
To perform a territorial breakdown we will adopt a model focusing on three components: needs, clienteles and services and the results. The data will be applied to four CLSC territories chosen according to predetermined parameters to facilitate the establishment of significant comparisons.

Work plan:
The first stage will be to define a program outline targeting contributions in social adjustment. Next, information will be collected on the three components proposed. For the first phase involving programs, we will limit our activities to analyzing data from the health and social service network which will be paralleled with data concerning needs and results. At the end of the first year of work, we will present our results to the Régie régionale in order to confirm our orientations and plan the continuation of our activities.

It should be noted that, to support the programming and coordination work in the youth sector, at the same time, we will produce all the relevant clientele and service data from the health and social service network for the 29 CLSC territories.

3.6.2 Services related to violence against women

SOLUTIONS FOR THE FUTURE TO DEAL WITH VIOLENCE AGAINST WOMEN

3.6.2.1 Coordinate the development of policies concerning sexual aggression and conjugal violence

3.6.2.2 Reduce social tolerance toward violence against women ›

3.6.2.3 Prevent violence among youth
3.6.2.4 Prevent isolation and increase the feeling of security among women
3.6.2.5 Increase the awareness of practitioners and ensure they receive the training and support required
3.6.2.6 Prevent recidivism in violence against women
3.6.2.7 Offer early screening and intervention services in order to be able to act against conjugal violence
3.6.2.8 Facilitate improvements in continuity of services between existing telephone assistance lines
3.6.2.9 Limit the repercussions of conjugal violence on child victims or witnesses of this violence
3.6.2.10 Establish cooperation protocols between the CLSCs, Centres jeunesse and other partners to improve coordination of interventions for victims and child witnesses

As one of the four regional priorities for promotion and prevention, in the 1998-2002 plan, interventions concerning violence against women already initiated in 1995-1998 will be continued and will target prevention objectives as well as reducing consequences harmful to the health and welfare of women.

Several recommendations were made in regard to this problem in the following:
- The health and welfare policy (1992);
- Agir pour Montréal. Policy and plan of action in community development (1992);
- Un avenir à partager. Policy concerning the situation of women (1992);
- Interventions for violent spouses. Orientations;
- Sexual aggression. STOP (1995);
- La politique d'intervention en matière de violence conjugale (Intervention policy concerning conjugal violence) (1995).

Principal points raised in the consultation:
- The Regroupement des CLSC as well as the group of shelters and transition homes for women victims of conjugal violence asked that their expertise be recognized and that the Régie régional acknowledge the front-line role they play in this area.
- Emphasis was placed on the urgency of acting with child witnesses or victims of conjugal violence, and to this effect, that existing protocols between institutions and organizations be used to improve coordination of interventions.
- It was suggested that services for women and child victims be distinguished from those provided to violent spouses.
- It was hoped that coordination would be established between the SOS conjugal violence line, the provincial line for violent spouses and the Info-Santé line.

A point constantly raised was the importance of increasing the visibility of existing front-line services for women victims, child witnesses or victims and abusive spouses and to ensure greater coordination between their activities.

The Régie régionale wishes that by the year 2002, all CLSCs in the Montreal region will provide universal screening services for women victims of conjugal violence and follow-up and referral services for them and for child witnesses or victims of conjugal violence as well as for the violent spouses.

The Régie régionale also seeks to ensure that acute-care hospitals in the Montreal region offer early screening and intervention services for women victims of conjugal violence.

It is hoped that by the year 2002, additional funds will be invested in the Montreal region for this purpose.

The Régie régionale, as mandatory for the performance of the intervention policy in regard to conjugal violence, will assume leadership among all the multisectoral partners to achieve its plan of action. Measures will be developed based on the four components developed in the policy, i.e. :
- Prevention;
- Screening
- Adapting to special realities;
- Intervening in conjugal violence:
  - in the psychosocial field
  - in the judicial and correctional field

PREVENTION/PROMOTION

3.6.2.1 Coordinate the development of policies concerning sexual agression and conjugal violence

Means of action:
- Support and facilitate overall, coherent, complementary and participatory actions of the players in all the networks involved (health and social services, justice and public security).

3.6.2.2 Reduce social tolerance toward violence against women

Means of action:
- Support the provincial campaign concerning violence against women;

- Raise the population's awareness and adapt the contents of messages for a number of ethno-cultural communities in the region.

3.6.2.3 *Prevent violence among youth*

Mean of action:

- As part of the integrated regional youth plan, facilitate the development of actions to prevent violence among youth and support awareness-raising and training for practitioners in the sectors involved.

3.6.2.4 *Prevent isolation and increase the feeling of security among women*

Mean of action:

- Develop regional and local intersectoral activities to act on the living environment as well as on social and environmental conditions and to increase women's independence.

3.6.2.5 *Increase the awareness of practitioners and ensure they receive the training and support required*

Means of action

- Provide training and support to key practitioners in acute-care hospitals as well as to physicians in private clinics so that they can improve screening and interventions with women victims of conjugal violence;
- Provide training and support for key practitioners in the CLSCs so that they can improve screening and interventions with women victims, child witnesses or victims and abusive spouses;
- Facilitate intersectoral action around awareness-raising activities, training and support of practitioners involved in the problem of violence against women.

3.6.2.6 *Prevent recidivism in violence against women*

Means of action:

- Facilitate the continuity and complementarity of services provided in the region to women victims, child witnesses or victims and abusive spouses;
- Develop cooperation agreements between institutions, the police and community organizations.

3.6.2.7 *Offer early screening and intervention services in order to be able to act against conjugal violence*

Means of action:

Using the resources they already have for this purpose:

- CLSCs shall provide screening, follow-up and referral services to women victims of conjugal violence as well as to child witnesses or victims of conjugal violence;
- CLSCs shall offer violent spouses screening, follow-up and referral services in cooperation with community organizations which have developed expertise in this field;
- CLSCs shall also adapt interventions in order to respond to the needs of specific clienteles or those more vulnerable to violence.

3.6.2.8 *Facilitate improvements in continuity of services between existing telephone assistance lines*

Mean of action:

- Establish a collaborative approach between the SOS conjugal violence line, the provincial assistance line for violent spouses and the Info-Santé line.

3.6.2.9 *Limit the repercussions of conjugal violence on child victims or witnesses of this violence*

Means of action

- Establish formal multisectoral cooperation agreements linking the CLSCs, Centres jeunesse, MUC police department, community organizations and the justice sector;
- Continue training for practitioners concerned, in regard to interventions with women as well as with children and abusive spouses.

3.6.2.10 *Establish cooperation protocols between the CLSCs, Centres jeunesse and other partners to improve coordination of interventions for victims and child witnesses*

Mean of action:

- Use existing protocols between the Centres jeunesse, the CLSCs, the police and community organizations.

3.6.3 Services concerning alcoholism and drug addiction

SOLUTIONS FOR THE FUTURE IN REGARD TO ALCOHOLISM AND DRUG ADDICTION

3.6.3.1 The Régie régionale proposes a development budget of $1.3M assumed by the health and social service network to ensure access to methadone treatment services for heroine addicts throughout the territory of Montreal

3.6.3.2 Extend the application of the regional program to promote health and prevent drug addiction to the entire Island of Montreal

3.6.3.3 Improve screening and early intervention and increase access to services offered in CLSCs to alcoholics and drug addicts

3.6.3.4 Develop complementary services for people experiencing alcoholism-drug addiction and mental health problems

3.6.3.5 Improve access to alcoholism and drug addiction services for English-speaking clientele

3.6.3.6 Develop drug addiction services for inmates in provincial facilities in Montreal

3.6.3.7 Develop community initiatives and control the quality of services offered in the private sector

In 1990, the "Orientations ministérielles à l'égard de l'usage et de l'abus des psychotropes" (Departmental orientations concerning the use and abuse of psychotropic drugs) as well as the "Rapport du groupe de travail sur la lutte contre la drogue - Rapport Bertrand" (Work group report on the struggle against drugs - Bertrand Report) indicated possible solutions and measures which could be proposed in regard to drug addiction in Quebec: the shift toward prevention, the choice of actions coordinated with other practitioners in society and the central position occupied by the individual in all interventions. On the regional level, a mandate was assigned to the Conseil régional de la santé et des services sociaux to coordinate all prevention activities according to orientations adopted by the government in regard to the struggle against drugs.

Commencing in 1991, the Conseil régional and, later on, the Régie régionale adopted and implemented a regional program to promote health and prevent drug addiction. Today, this program covers sixteen CLSC territories.

In 1993, the new Act respecting health services and social services merged the boards of directors of the three drug addiction rehabilitation centres in Montreal which became the Centre Dollard Cormier in 1997.

The Plan to reorganize the network for 1995-1998 did not include any measures directly focusing on drug addiction, other than the objective to improve the efficiency of rehabilitation centres.

The Plan for 1998-2002 seeks to improve services through an integrated service network which will integrate the entire continuum: promotion, prevention, early intervention, rehabilitation and reintegration.

Principal points raised during the consultation:
The following points raised during the public hearings will orient our choices:

- The necessity to invest in the field of drug addiction in view of the enormous social costs created by this problem;
- The commitment of the partners to an intersectoral approach to problems related to drug addiction;
- The need for strong regional leadership in regard to the creation of an intersectoral funding strategy;
- The severity of the morbidity and mortality caused by heroine consumption and the urgency to intervene in order to increase access to methadone treatment;
- The necessity to ensure a continuum of quality services for people suffering from both drug addiction and mental health problems;
- The importance of early intervention in order to prevent drug addiction.

A regional intersectoral plan for Montreal:
The objective of this plan will be to implement of an integrated network of services concerning alcoholism and drug addiction for the Montreal-Centre region; it will integrate the entire range of services in the continuum.

Priorities in the plan of action:
The proposed measures are designed to reduce the harm related to the use of psychotropic drugs. They have been selected in view of the urgency to protect health due to the situation concerning drug addiction in Montreal and the information provided in the notices received during the public hearings. Funding for the plan of action will be assumed jointly by the health and social service network and by the other multisectoral partners concerned by the consequences of abuse in the consumption of alcohol and drugs.

3.6.3.1 *The Régie régionale proposes a development budget of $1.3M assumed by the health and social service network to ensure access to methadone treatment services for heroine addicts throughout the territory of Montreal*

In 1996, according to Dr. Pierre Lauzon who testified as an expert during the Régie régionale's public hearings, it was estimated that there were between 8,000 and 15,000 active injectable drug users on the Island of Montreal.

Of this number, 5,000 people inject heroine or other drugs such as cocaine, depending on which drugs are available on the illicit drug market[31].

The practice of injecting drugs involves a 5% risk of HIV infection[32] and as much as 20% for detainees in custodial facilities in Montreal, as well as generalized risks of viral hepatitis infections and a death rate of up to ten times that of the population in the same age group, due to overdoses, suicides and infections related to sharing dirty syringes. Sexual partners and children of people who inject drugs are exposed to the same risks.

Methadone treatment, as a substitute medication, enables the youth and adult heroine addict to reduce the risks associated with injecting drugs. In addition, access to this treatment creates a confidential relationship with practitioners who are able to accompany the drug addict to services appropriate to his/her condition and needs.

Currently, access to methadone treatment reaches approximately 500 people, representing 10% of consumers.

Recognizing the lack of access to services for drug addicts and the existence of an adequate treatment for this condition, the Régie régionale considers treatment of heroine addicts is a regional priority and has set an objective to ensure access to methadone treatment services for these people.

Anticipated result:
In order to achieve accessibility standards recognized as being satisfactory (50% of the total number of heroine addicts in a given region), by 2002, the Montreal region will be able to offer a range of treatment services to 2,500 of the 5,000 heroine addicts in the metropolitan area.

Means of action:

- Support to reinforce the visibility and development of links between the various gates of entry on a regional level in regard to access to methadone treatment;
- Support in training first-line physicians, medical residents and staff in public drug addiction rehabilitation centres;
- Support for substitution interventions for which there is very little demand;
- Support for interventions among detainees in provincial facilities;
- Support for brief methadone interventions.

Condition for performance
The additional budget required from the Ministère de la Santé et des Services sociaux for this measure: $1.3M.

3.6.3.2 *Extend the application of the regional program to promote health and prevent drug addiction to the entire Island of Montreal*

Mean of action:
The regional promotion and drug addiction prevention program is designed for youth and their parents. The objective is to develop responsible behavior in regard to alcohol and drug consumption. This program currently covers thirteen CLSC territories. By 2002, the regional program to promote health and prevent drug addiction will be developed throughout the territory

Conditions for performance:

- Increase the budget of the regional program by $423,305;
- Funding: intersectoral budget.

3.6.3.3 *Improve screening and early intervention and increase access to services offered in CLSCs to alcoholics and drug addicts*

Mean of action:
Develop reception and assessment services and follow-ups for young pregnant women and marginal youth and facilitate access to sterile syringes.

Conditions for performance:

- Additional budget of $1.5M;
- Intersectoral funding.

3.6.3.4 *Develop complementary services for people experiencing alcoholism-drug addiction and mental health problems*

A great many drug addicts also suffer from severe mental health problems.

Mean of action:

- Innovative projects will be developed jointly by hospitals,

[31] (Rémis R. 1998).

[32] (Bruneau J.1997).

CLSCs, alcoholism and drug addiction rehabilitation centres and community organizations, to ensure the quality of the case management for this clientele.

Conditions for performance
- Additional budget of $500,000;
- Intersectoral funding.

3.6.3.5 *Improve access to alcoholism and drug addiction services for English-speaking clientele*

Emergency drug addiction services for English-speaking people are insufficient and services for English-speaking youth are incomplete.

Means of action:
- Establish a 24-hour drug addiction emergency service for English-speaking people, with the participation of the emergency service which provides services in French;
- Develop six places in a group home for English-speaking youth with the participation of the rehabilitation centre and the Batshaw Youth and Family Centres.

Conditions for performance:
- Additional budget of $450,000;
- Intersectoral funding.

3.6.3.6 *Develop drug addiction services for inmates in provincial prison facilities in Montreal*

There are no drug addiction services for clientele in custodial facilities although this population includes many drug addicts and seropositivity is very prevalent. A methadone treatment program for detainees who are heroine addicts must be developed with the participation of the Ministère de la Sécurité publique and the health and social service institutions.

Conditions for performance
- Additional budget $200,000;
- Intersectoral funding.

3.6.3.7 *Develop community initiatives and control the quality of services offered in the private sector*

The ability for community organizations involved in drug addiction to act is limited by a lack of resources.

A regional quality control mechanism for drug addiction services in the private sector is also required.

Conditions for performance:
- Additional budget of $600,000;
- Intersectoral funding.

3.6.4 Services for the homeless

SOLUTIONS FOR THE FUTURE FOR HOMELESS PEOPLE

3.6.4.1 Improve the integration of actions designed for homeless people in the service continuums: physical health, mental health, intellectual impairment, alcoholism, drug addiction and AIDS, and ensure access to services

A study performed 10 years ago estimated the number of homeless clientele at around 15,000 people[33]. Another census is currently being performed and the first data should be available by May, 1998.

Various indicators nevertheless lead us to believe that the number of homeless people in the region is on the rise. These include the increase in the number of community resources serving this population, the increasing numbers of people who frequent these resources, the occupation rate of shelters which are maintained at their maximum and the number of new users identified by the people in charge of these resources.

The current economic and social situation seems to have a significant impact on homelessness. In this regard, it should be mentioned that, among the many factors which seem to influence the number of homeless people, changes in certain social policies including those affecting income and housing appear to have had an effect. The increase of poverty in the population is an important factor, as is the disinstitutionalization process in mental health, which also seems to increase the presence of vulnerable homeless people. Other social problems which are omnipresent in a metropolis, such as drug consumption, delinquency, etc., phenomenon which are continually on the rise, also lead us to believe that they contribute to increasing the phenomenon of homelessness.

Finally, the job market and the increasing difficulty in the school-to-work transition. particularly for youth, the lack of essential relationships, the increasing number of people who are socially isolated and the migration of the population to Montreal due to its metropolitan situation are also factors which contribute to this diagnosis.

[33] Louise Fournier et Céline Mercier, Sans domicile fixe : Au delà du stéréotype., Éd. Méridien, 1996, 59.

Homeless clientele are heterogeneous and composed of a diversity of sub-groups, for example: marginalized youth, women experiencing difficulties, persons leaving institutions (ex-psychiatric cases, persons with an intellectual impairment, persons from a prison environment, people suffering from multiple problems (mental health, AIDS, alcoholism and drug addiction).

This clientele is also characterized by diverse problems and needs, including: isolation, physical and/or mental health or behavioral problems (school drop-outs, drug addicts), housing, etc.

In terms of services, in spite of the efforts made, several lacks need to be filled and certain adjustments made.

Principal points raised in the consultation:

- Efforts should be oriented more toward an overall approach and actions must be integrated;
- The phenomenon of homelessness must be specifically recognized;
- Community action must be supported and consolidated;
- Access to health care and services must be improved;
- The coordination and continuity of services must be secured;
- Social reintegration must be facilitated.

3.6.4.1 *Improve the integration of actions designed for homeless people in the service continuums: physical health, mental health, intellectual impairment, alcoholism, drug addiction and AIDS, and ensure access to services*

Means of action:

A committee on homelessness currently groups three networks (health and social services, community, municipal). This committee is coordinated jointly by the Régie régionale, the Réseau d'aide aux personnes seules et itinérantes and the municipal environment. It is composed of people from these three networks representing different categories of institutions and organizations involved in working with the homeless as well as the various municipal services concerned.

In order to better integrate actions and to develop specific service plans for the homeless, the Régie régionale:

- recognizes the importance of the planning and coordination role of this joint committee in regard to the problem of homelessness;
- intends to invest its energies, as part of the coordination of this joint committee, to facilitate both the introduction of measures to prevent homelessness as well as measures to adjust and improve the services in the health and social service network for this clientele.

Prevention measures:

- Intervene "before the problem appears" with youth experiencing difficulties and at risk of becoming homeless and act early with youth who are becoming marginalized;
- Establish close collaborations between the CLSCs and the community organizations involved with marginalized youth;
- Develop programs to prevent youth from dropping out of school, working with the partners concerned (parents, schools, employers);
- Develop measures for social reintegration of youth experiencing social adjustment difficulties (rehabilitation, development of employability, housing, social network);

Curative and social reintegration services:

- Contribute to the development of community support in social housing;
- Adjust the organization of services for homeless people suffering from severe and persistent mental disorders;
- Develop access to CLSC services for homeless people;
- Make physical and mental health services available;
- Introduce the programme régional d'intervention auprès des utilisateurs de drogues injectables / UDI (regional intervention program for injectable drug users)
- In the CLSC territories where there is a concentration of homeless people:
- Make the previously mentioned services accessible in the shelters frequented by the clienteles;
- Develop "outreach" services for homeless people.
- As part of the shift toward ambulatory services, ensure access to acute-care services and adapt services for the homeless clientele:
- Adapt linkage mechanisms between general and specialized hospitals - CLSCs - attending physicians for the special needs of homeless people:
  - physical health
  - mental health
- Revise and adapt the regional organization of AIDS shelter services for homeless clientele

Training:

- Establish activities enabling practitioners to improve their understanding of the problems faced by homeless people and the resources available (mission and services).

3.6.5 Services concerning AIDS

SERVICES FOR THE FUTURE IN REGARD TO AIDS

3.6.5.1 Implement a regional plan for HIV/AIDS and other STDs in line with the Quebec strategy for combating AIDS - Phase IV: 1997-2002, within a service continuum including prevention/promotion activities and care and services.

The activities to be performed by the Régie régionale for 1998-2002 are part of phase 4 of the strategy for combating AIDS, adopted by the Ministère de la Santé et des Services sociaux and are based on the following:

- A great deal of progress has been made in therapeutic treatment; there are now many different and more complex treatments, new antiretroviral molecules and a test to measure viral count which have had a considerable impact on biomedical follow-ups. These therapeutic changes have also affected the service needs of the clientele. Practitioners must have specific knowledge and new skills in order to deal with the complexity of the new treatments.
- Since 1994, the number of cases of AIDS has decreased in the Montreal region, probably due to the impact of new therapies against HIV and treatments for complications associated with the infection. Although there is little data available, certain studies indicate that there is still a great deal of transmission of HIV among certain population sub-groups.
- People with AIDS often suffer from several problems including drug addiction, homelessness, mental illness, delinquency, etc. Prevention/promotion measures and care and services must be adapted to the special needs of these people and to the development of their pathologies. Interventions performed with these vulnerable clienteles must take into account the many associated problems (drug-addiction, sexuality, prostitution, abuse, violence, hepatitis, etc.).
- Finally, the transformation of the health and social service system must include a revision of the service provision system for this clientele.

Principal points raised during the consultation:

- The notices submitted mention the necessity of adjusting services to the new reality of AIDS and the importance of questioning current practices. The Régie régionale must adopt its plans accordingly and provide the necessary leadership.
- Intervention approaches must be adapted to a clientele with multiple problems.
- Prevention of AIDS must become the responsibility of all community organizations and not only those involved with this clientele.

3.6.5.1 Implement a regional plan for HIV/AIDS and other STDs in line with the Quebec strategy for combating AIDS - Phase IV: 1997-2002, within a service continuum including prevention/promotion activities and care and services

The Régie régionale will assume leadership in the performance of this plan; work will be undertaken jointly by the Department of Public Health and by Programming and Coordination.

Priorities include the following:

- Development of an integrated service plan for the various clienteles targeted by the problem of HIV/AIDS and the implementation of an intersectoral consultation mechanism (drug addiction, homelessness, mental health, AIDS).
- Revision of the mandates of the CLSCs' specialized AIDS teams and the organization of screening and counseling services (including anonymous screening).
- Re-evaluation of needs and adaptation of services and resources in terms of prevention, promotion, protection and care for high-risk clienteles and those with HIV:
  - UHRESSS and satellite hospitals;
  - community organizations;
  - SIMAD AIDS;
  - etc.
- Development of the regional HIV prevention program and organization of first-line services for injectable drug users and marginal youth.
- Reinforcement of vigilance and supervision activities to facilitate the adjustment of interventions and the organization of services.
- Reinforcement of support mechanisms to develop practitioners' skills:
  - organization of training sessions;
  - development of mechanisms to facilitate the transfer of expertise;
  - information for physicians on existing programs related to STD/HIV/AIDS.

SUMMARY OF THE MEASURES IN ALL SERVICE CONTINUUMS DESIGNED FOR CHILDREN, YOUTH AND YOUNG ADULTS

1. CONTINUUM OF PHYSICAL HEALTH SERVICES

Measure 3.1.4 :
In order to improve the organization of ultraspecialized services, the plan proposes establishing joint regional programs (UHC Sainte-Justine and CUSM/Montreal Childrens' Hospital) offering pediatric care and services in certain medical subspecialties. These programs involve cardiac surgery, tertiary cardiology, neurosurgery and organ transplantation.

Measure 3.1.10 :
Improve the accessibility of radio-oncology in O.R.L. for pediatric clientele.

Measure 3.1.11 :
Improve access to pediatric cardiac surgery in order to eliminate the waiting list which includes 24 children and to provide for a maximum waiting period of one month with urgent cases carried out without resulting in longer delays for children on the regular waiting list.

2. CONTINUUM OF SERVICES FOR PEOPLE WITH A PHYSICAL IMPAIRMENT

Measure 3.3.5:
Allocate $1M for the CLSC subsidy program offering support to families of people with physical impairments. Combined with the CLSC program offering support to families of clientele with intellectual impairments (allocation of an amount of $2.3M, see measure 5.3) the funds assigned to these 2 programs concern more than 75% of the infancy, youth and young adult clientele.

Measure 3.3.7:
The Plan proposes inventorying adaptation/rehabilitation services provided for:

- pediatric clientele with a motor impairment;
- clientele with a sensory impairment (all ages);
- clientele with language or speech disorders (all ages).

The Plan also proposes inventorying the different types of support services currently available for families living with a person (of any age) who has a physical impairment in order to adapt the range of services provided to the diversified needs of the families in the most efficient manner possible. The plan will provide a better understanding of certain problems so that actions can be oriented for the future in regard to the consolidation of rehabilitation focusing on social integration (These measures also apply to clientele with multiple handicaps).

3. CONTINUUM OF MENTAL HEALTH SERVICES

Measure 3.4.4:
Prevention of suicide among high-risk clientele including child-youth clientele.

Measure 3.4.5:
Ensure access to child psychiatry services to children and youth. This measures is designed for the child as well as for children whose parents are suffering from mental health problems.

4. CONTINUUM OF SERVICES FOR PEOPLE WITH INTELLECTUAL IMPAIRMENTS

Measure 3.5.1:
Program offering support to the person, the family and the community

- CRDPI: Adjustment services and support for the person, the family and relatives, including early stimulation services. This portion of the measure will serve 500 people on the waiting list, 75% of whom are children and young adults.
- CLSC: Services offering support to the family. Budget of $2.3M combined with measure 3.3.5 ($1M), 75% of the funds allocated concern children, youth and young adults.

5. CONTINUUM OF SOCIAL ADJUSTMENT SERVICES

YOUTH

Measure 3.6.1.1:
By the year 2002, develop a shared and mobilizing youth project in Montreal designed for youth and their parents

Measure 3.6.1.2:
As part of the youth project and in keeping with its orientations, develop four specific intervention programs to provide effective action in combating parental negligence, family violence toward children, violence during adolescence, exclusion and marginalization

Measure 3.6.1.3:
During 1998-2002, employing the same orientations as the priority youth program, intensify prevention/promotion interventions and all forms of interventions performed before the need for services appears

Measure 3.6.1.4:
Improve access to services in each CLSC territory and on a regional level.

Measure 3.6.1.5:
Introduce coordination and participatory mechanisms in each of the CLSC territories and at the regional level, to reinforce the unity of action of the sectoral and intersectoral players

Measure 3.6.1.6:
As part of the implementation of the youth project, consolidate and improve the integration of specialized services to support interventions performed close to natural living environments.

Measure 3.6.1.7:
Improve our intersectoral strategies by preparing a breakdown chart to analyze and compare investments, needs and results at a local level.

VIOLENCE AGAINST WOMEN

Measure 3.6.2.1:
Coordinate the development of policies concerning sexual agression and conjugal violence (preventive measures).

Measure 3.6.2.3:
Prevent violence among youth.

Measure 3.6.2.9:
Limit the repercussions of conjugal violence on child victims or witnesses of this violence.

Measure 3.6.2.10:
Establish cooperation protocols between the CLSCs, Centres jeunesse and other partners to improve coordination of interventions for victims and child witnesses.

ALCOHOLISM AND DRUG ADDICTION

Measure 3.6.3.2:
Extend the application of the regional program to promote health and prevent drug addiction to the entire Island of Montreal

Measure 3.6.3.3:
Improve screening and early intervention and increase access to services offered in CLSCs to alcoholics and drug addicts.

Measure 3.6.3.5:
Improve access to alcoholism and drug addiction services for English-speaking clientele (including youth).

HOMELESSNESS

Measure 3.6.4.1:
Improve the integration of actions designed for homeless people (including marginalized youth) in the service continuums: physical health, mental health, intellectual impairment, alcoholism, drug addiction and AIDS, and ensure access to services (preventive and curative measures).

AIDS

Measure 3.6.5.1:
Implement a regional plan for HIV/AIDS and other STDs in line with the Quebec strategy for combating AIDS - Phase IV: 1997-2002, within a service continuum including prevention/promotion activities and care and services.

3.7 SUMMARY OF THE IMPACTS ON SERVICES TO THE POPULATION, TRANSPORT OF BENEFICIARIES, EXPECTATIONS IN REGARD TO THE CLSCS, INFORMATION SYSTEMS AND FINANCIAL RESOURCES

The Plan to improve services for 1998-2002 puts greater emphasis on integrating promotion and prevention activities within the service continuums and effective networking between the various components in the range of services and the partners in each service continuum.

We are also proposing improvement priorities to ensure significant progress is made in the accessibility of services significant to the health and welfare of the population.

3.7.1 The impact on services to the population

The Plan for 1998-2002 proposes several measures which will result in significant improvements for the population in the accessibility and quality of services.

CONTINUUM OF PHYSICAL HEALTH SERVICES

First-line medical services:

- As part of the establishment of the département régional de médecine générale - DRMG (regional department of general practice):
  - Ensure access to medical consultation services with an appointment with no more than a four-week waiting period;
  - Ensure access to medical consultation walk-in services at recognized sites, 365 days per year from 8 a.m. to 10 p.m.;
  - Ensure access to medical consultation services in the home for clientele registered with the CLSC program, within no more than 48 hours or within two-weeks, depending on the need;
  - For clientele registered with the CLSC program, establish an on-call network on a sub-regional basis, a medical transition team for post-hospitalized patients who have complex health problems and a team of physicians to provide palliative care;
  - Ensure access to medical consultation services in residential and long-term care centres and in rehabilitation hospitals and centres.

General and specialized services in general and specialized care hospitals:

- Maintain 6,062 acute physical care beds, corresponding to 2.2 beds / 1,000 inhabitants for a population pool of 2.7 million inhabitants.
- Implement a permanent solution to congestion in emergency departments so that patients never spend more than 24 hours there. The introduction of five ambulatory care centres are part of the solution.
- Decrease surgery waiting lists in general and more specifically in four specialties:
  - Cardiac surgery
    For adults:
    The Plan proposes eliminating the waiting list of 364 patients and then limiting the waiting period to a maximum of 1 month.
    For children:
    Eliminate the waiting list of 24 children, ensure a maximum waiting period of one month and that urgent cases can be performed without extending the waiting period for other children on the list.
  - Orthopedics (hip and knee prostheses)
    There are 1,220 patients on the waiting list. The Plan proposes reducing the maximum waiting period to 6 months, which means that 670 cases must be performed rapidly. Following this, the number of operations performed each year must be increased gradually so that, by the end of 2002, there will be an additional 171 arthroplasties of the hip or knee performed each year.
  - Ophthalmology (cataracts)
    There are 6,800 patients on the waiting list. The Plan proposes reducing the waiting list by 2,000 cases to bring the maximum waiting period to 6 months. Following these measures, the number of cataract operations performed per year must be increased so that by the year 2002, 2000 more operations are being performed than now, thereby keeping the waiting period to less than 6 months.
    The need for additional cases has been calculated according to the average increase in waiting list volume per month.
  - Neurosurgery (brain tumors)
    Eliminate the waiting list of 30 patients who have been waiting for more than one month and reduce the waiting period to less than one month.
- Attain 100% of the day surgery potential, representing 10,000 more cases (according to data from 1995-1996).
- Perform 85% of planned surgeries on the day of admission.
- Decrease the average hospital stay to 6.8 days by introducing a tool to evaluate the pertinence of hospitalizations and lengths of stay.

- Maintain the population's access to critical services where needs are continually increasing due to the aging of the population. These are:
  - Tertiary cardiology
    The Plan includes an amount to cover 30 cardiac defibrillators, following which, in order to meet the needs of the population by the end of 2002, 60 more defibrillators must be added to the current number each year.
  - Kidney dialysis
    In order to meet the increasing needs of the population by the year 2002, we must treat an additional 104 patients, representing a total of 1379 dialysis patients in the region.
  - Organ transplants
    Perform 18 additional transplants for a total of 285 transplants in 1999-2000 and 36 more for the two following years for a total of 357 transplants in 2002, in accordance with the objectives targeted by Québec Transplant.
  - Neurosurgery
    Implant 15 neurostimulators to control pain in order to take care of the waiting list and increase access to perform 50 implants per year by the year 2002.
- Establish five ambulatory care centers:
  1) Lakeshore
  2) Maisonneuve-Rosemont
  3) Sacré-Coeur
  4) CHUM
  5) MUHC
  in order to continue the shift toward ambulatory care and to take advantage of technological developments to deal with complex cases on an ambulatory basis.
- Increase the number of resources in the 29 CLSCs in order to meet all requests for post-hospital care.
- Establish walk-in specimen collection services in the 29 CLSCs.
- Establish an integrated care model for palliative care.

CONTINUUM OF SERVICES FOR THE ELDERLY

- Raise admissions criteria for 2,326 beds in residential and long-term care centres so that they can receive a clientele who require 2.5 care-hours per day or more. This will increase the proportion of places able to receive this type of clientele to 60%; the proportion is currently 44%;
- This measure will allow us to deal with the anticipated 25% increase in the elderly population over the age of 75 by the year 2002, with 14,569 beds in residential and long-term care centres and general and specialized care hospitals (a reduction of 100 beds);
- Improve the rate of response to needs in residential and long-term care centres in order:
  - to attain a rate of response in nursing care and assistance (PLAISIR) of at least 80%;
  - to attain an acceptable level of services in occupational therapy, physiotherapy, directed activities and social services;
  - to maintain the bed occupation rate at least 99.4%.
- In order to make better use of acute-care hospital beds and to serve the elderly in need of placement in the right place, reduce the number of transition beds in general and specialized care hospitals by 10%, from 888 to 552 beds. To ensure this number of beds is sufficient to meet needs while reducing waiting periods, the rate of requests for placement[34] from general and specialized care hospitals in the region must be maintained at no more than 8%;
- Increase CLSC home-care services in order to:
  - attain a percentage of potential clientele served of 80% (compared to 58% currently);
  - increase the number of people served who require between 1.5 and 2.5 care-hours and assistance per day by 34%; bringing the number of people served from 878 to 1,178;
  - increase home-care services by 26% for people under the age of 65 years who are experiencing a loss of autonomy and premature aging, bringing the number of clients served from 14,603 to 18,356;
  - ensure an adequate response to unplanned home-care services during evenings, the night, weekends and on holidays by consolidating the CLSCs' 24/7 centres.
- Develop a day centre for English-speaking clientele in order to reduce the waiting list;
- In order to meet the increasing demand, reorganize temporary placement services, increase the occupation rate of existing places to 90% and add 35 new places;
- Extend the range of services available for the clientele by developing 400 places in non-institutional residential resources, of which 40 will be assigned to adults under the age of 65 years;
- Continue implementing the single window approach for access to services.

CONTINUUM OF SERVICES FOR PEOPLE WITH PHYSICAL IMPAIRMENTS

- Consolidate intensive functional rehabilitation services by increasing out-patient services and intensifying rehabilitation to 7 days/week.

[34]The rate of placement requests is the number of placement requests made in one year by a hospital, divided by the total number of people aged 75 years or more admitted to hospital as an emergency in the same year.

- Provide home rehabilitation services for 728 patients who had had an arthroplasty of the hip or knee.
- Eliminate the waiting list of 245 people for intensive home-care services. Also increase access for 281 people by the year 2002.
- Eliminate the waiting list of 114 people in need of family support services and ensure a response to the needs of an anticipated 208 new families by the year 2002.

CONTINUUM OF MENTAL HEALTH SERVICES

- Develop mental health services in the community and in adapted living environments for 390 people, representing:
  - 180 in community services and resources;
  - 60 in adapted places in residential and long-term care centres;
  - 150 in regular places in residential and long-term care centres;.

  This will be made possible by closing 350 long-term beds, as follows:
  - 50 by natural attrition;
  - 150 because people experiencing a loss of physical autonomy will be directed to residential and long-term care centres;
  - 150 because people will be reintegrated in the community.
- By 2002, raise the average rate of users served on an ambulatory basis versus in hospital, from 83.6% to 90%.
- Improve access to basic mental health services in CLSCs by:
  - adding 50 full-time practitioners assigned to reception, assessment, referral and brief intervention duties. (On a basis of 8 interventions per year per user, this additional staff will enable around 2,500 users to be reached per year. This will mean more people will be served in their local community, which will help reduce congestion in emergency departments. Finally, these practitioners will assume important liaison duties, on a local basis, with self-help groups, families, crisis centres, medical clinics, private medical practices, etc.).
- Establish a 24/7 telephone listening service offering telephone assistance, support and referrals in order to respond to approximately 200,000 calls per year.
- Improve the structure and adjust hospitalization services by:
  - eliminating stays of more than 48 hours in the emergency department;
  - reducing the average length of acute-care hospitalization to 20 days;
  - opening 25 beds and enhancing 50 regional long-term beds in order to liberate acute-care units and departments of their long-term cases;
  - applying a standard of 0.35 bed/days/presence/acute-care hospitalization per 1,000 inhabitants by maintaining 588 acute-care beds and transforming 118 beds of the same type to ambulatory services.

CONTINUUM OF SERVICES FOR PEOPLE WITH INTELLECTUAL IMPAIRMENTS

- Permanently eliminate all waiting lists for services by making residential and socio-occupational services available to the 1,092 people waiting for the 1,319 services required.
- Serve everyone waiting for services providing support to the person, the family and the community. Currently, 271 people are waiting for these services. It is estimated that 757 people will require services in the year 2002.
- At the end of the Plan, all requests for services must have been filled, representing 2,076 services (1,319 + 757); the intellectual impairment network will be able to respond to the clientele according to demand.

CONTINUUM OF SOCIAL ADJUSTMENT SERVICES

Youth

- In each of the CLSC territories, establish a shared and mobilizing youth project in order to correct deficiencies concerning the accessibility, continuity and integration of youth services, including both preventive and curative services.
- Develop youth projects by grouping together sectoral and multisectoral strengths in the environment and present them to the Régie régionale by December 1998.
- As part of the youth projects, develop four specific programs of preventive and curative interventions in regard to parental negligence, family violence toward children, violence among adolescents and marginalization.
- Improve intersectoral strategies by preparing a breakdown to enable an analysis and comparison of investments, needs and results at a local level.

Alcoholism/drug addiction

- Make methadone treatment available to heroine addicts in Montreal according to accessibility standards recognized as satisfactory, i.e. 2,500 cases.
- Extend the regional health promotion and prevention of drug addiction program to all CLSC territories (addition of 16 territories to the 13 already served). (Intersectoral funding strategy).
- Increase the capacity of the CLSCs to perform screening

and early intervention and improve access to services for alcoholics and drug addicts by adding 29 practitioners (1 X 29 CLSCs).
- Establish two experimental projects for clientele suffering from the double problem of mental health and drug addiction.
- Provide detainees in provincial institutions with psychosocial services and methadone treatment.
- Improve access to alcoholism and drug addiction services for the English-speaking clientele by establishing an emergency service for this clientele and opening places for youths addicted to drugs.

3.7.2 The problem of providing transport for beneficiaries

During the public hearings, many participants expressed their concern in regard to the current difficulties involving access to transport services for beneficiaries in the network. Whether they involve regular public transport or adapted transport services, the two following situations must be dealt with:

- **Social integration and disinstitutionalization**
  These trends, to which the health and social service network has been committed over the past few years, have had a major impact on increasing needs for transport. Movement of users in this area is continuing and the reorganization of the mental health sector will undoubtedly also have an important impact.

- **Aging of the population**
  With aging of the population, needs for transport change. On one hand, the loss of autonomy which often accompanies this aging, limits the use of a personal vehicle and increases the demand for regular public transport and in particular adapted transport. On the other hand, accompaniment problems are increasing and must be considered in preparing means of adapted transport.

- **The shift toward ambulatory services**
  The effect of the shift toward ambulatory services reduces the length of hospital stays. People who leave the hospital sooner must return or report to a clinic or a CLSC for a medical follow-up. Sometimes a personal vehicle can be used or a member of the family can provide transportation. More often, the person requires special transport services due to a temporary disability or specialized equipment being used (e.g. oxygen tank, etc.). These situations will become increasingly frequent as the shift toward ambulatory care is implemented. For many players in the transport field, the success of the shift toward ambulatory services rests on the coordination and organization of appropriate and effective transport methods. Within this context, coordination mechanisms and a concrete organization plan of transport methods must be planned.

- **Budget cuts**
  As we have seen, needs for transportation are increasingly numerous and diverse. At the same time, transportation programs are also suffering from the effect of the government's massive budget cuts. Requests are increasing while the funds allocated, at best, remain the same.

  Combined with the effects of the shift toward ambulatory care, social integration and disinstitutionalization, and the aging of the population, the transport problem is critical.

The general portrait of transportation in Montreal is complex. Many organizations assume responsibilities in regard to transport: institutions in the network, community organizations, the MUCTC (regular and adapted transport), the private sector. Several government departments also subsidize or offer certain transport services:
- Ministère de la Main-d'oeuvre et de la Sécurité du revenu et de la Formation professionnelle;
- Department of National Health and Welfare;
- Ministère de la Justice du Québec;
- Commission de la santé et de la sécurité du travail (CSST).

In view of this situation, the Régie régionale intends to:
- ensure the production and up-dating of an inventory of vehicles, means of transport and transport programs available in the health and social service network;
  - This repertory of resources will primarily be used to provide the network with more information and should encourage institutions and organizations to establish cooperative agreements and unite their efforts in the transport field. The difficult period we are experiencing on the economic level is obviously not conducive to development budgets. Exchanging and sharing existing means can only simplify the transport problems in the metropolitan region.
- avoid reducing the resources assigned by the institutions for transport of beneficiaries. Remind the institutions of their responsibility in regard to the transport needs of their clientele.
- provide coordination mechanisms and a concrete organization plan of the means of transport in the network.
- develop intra and inter-network collaborations in order to maximize the use of fleets of vehicles and other means and the transport programs used by the network and by other networks (particularly education).

- maintain and even increase the participation of the Régie régionale in consultation and work groups concerning transport, particularly on the integration of means of transport, adapted taxis, intershore transport, the comité usagers-transporteurs du transport adapté and others.

3.1.3 The impact on expectations in regard to the CLSCs

The CLSC continues to be an institution which offers the services required by practically every type of clientele in the health and social service network in their territory and is called on by all the service continuums.

The scope of the CLSCs' multiclientele and multidisciplinary mission, as well as its relative proximity in the community requires a wide variety of services, both preventive and curative, including health, psychosocial, rehabilitation and reintegration services. CLSCs must adapt their response to the needs of clienteles with many different problems.

For the citizen, the CLSC must become an important KEY, familiar and effective, providing access to the health and social services needed, no matter what the problem and whether or not the services are dispensed by the CLSC itself.

Having made this statement, it is also evident that we cannot ask the CLSCs to do everything at the same time with relatively the same resource pool.

The necessity to prioritize the Régie régionale's expectations in regard to the CLSCs and to clearly target their contribution for the next four years, supported by an effort to provide them with the necessary resources when required, is without doubt one of the most important points raised during the consultation.

Target 1 - Home-care services

Consequently, the main priority targeted for the CLSCs continues to be home-care services. Needs are still very extensive in this field and affect the most vulnerable populations who are also most liable to call on our health system for services in several service continuums.

In offering the right service, to the right person, in the right location at the right moment and at the best cost, CLSCs are identified as playing a major role in finding solutions for people of all ages experiencing a loss of autonomy, for the handicapped and for patients requiring post-hospital care (whether they require palliative, post-natal, post-operative or post-medical treatment, or intensive rehabilitation services in the home) as well as their relatives.

Over the years, the CLSCs have developed a wide expertise in home-care services. They have demonstrated their effectiveness in dealing with shifts in a network in constant change, particularly in the application of the regional plan for 1995-1998 "Achieving a new balance", and their ability to respond to the mandates and responsibilities assigned to them. They are an essential link in the new organization of health and social services.

For this reason, to consolidate and improve the accessibility of home-care services, the Régie régionale intends to inject an additional $36.2M in the CLSCs over the next four years.

Target 2 - Mental health

Among the other targets retained, we intend to reallocate $3.3M for basic mental health services by the year 2002, while encouraging a more efficient use of resources as well as linking services closer together, whether they are provided by hospitals, CLSCs or community groups.

To follow up comments received concerning 24 hour/7 day telephone access to information and referral services for mental health, the Régie régionale must up-date the service concept, identify the provider(s), specify the impacts, interfaces and throughput for other providers including CLSCs and other telephone crisis lines.

Target 3 - Infancy/family/youth

The Régie régionale is similarly concerned by services developed for children, the family and youth in all dimensions of the continuum, from prevention/promotion to rehabilitation/reintegration, including first-line and protective interventions. There are no plans for development, reallocations or new sharing models between the CLSCs and Centres jeunesse, or between the CLSCs and Santé publique. However, further to the desire expressed during the Youth Forum and hearings in March 1998, under the leadership of the Régie régionale, the principal sectoral players in the health and social service network, which include the CLSCs, Centres jeunesse and Direction de la santé publique, will be invited to link their interventions on a local CLSC territorial basis around common and mobilizing youth projects, together with partners from other sectors, such as schools, community groups, police and municipal services.

Target 4 - First-line medical prevention/promotion services

As important players in dispensing first-line services, the CLSCs have an essential role to play in prevention/promotion, which is not only recognized in the Act but is also acknowledged by all its partners.

To fulfill this role they must maintain their contribution and protect the level of resources and energy assigned, while continuing to show creativity and flexibility in their approaches (e.g.: the use of Info-santé in prevention strategies, better integration and application of prevention through curative services, a critical activity report in prevention/promotion).

Maintaining this investment is particularly important in that the CLSCs are considered as first line practitioners in attaining objectives which are related to the new provincial priorities in public health. The linkage between services dispensed by the CLSCs at the local level and those provided by the Direction de la santé publique on the regional level, must be based on these priorities.

The CLSCs will be called on to make a special effort to assign their prevention/promotion resources in each territory to projects of the type "Naître égaux, grandir en santé" and to participate in local, intersectoral plans of action designed to ensure the optimum development of youth in priority territories. The same effort will be asked of the Centres jeunesse.

Target 5 - First-line medical services

In regard to the CLSCs' medical services, the emphasis will be placed on the creation of the Département régional de médecine générale / DRMG (Regional department of medical practice) which will establish an integrated network of first-line medical services. The CLSCs will be invited to establish connections with medical clinics and private practices in order to consolidate medical consultation services with or without an appointment in all the territories, taking the resources available in each territory into account.

The organization of walk-in medical services offered every day of the week from 8 a.m. to 10 p.m., 365 days per year, will be consolidated in all the sub-regions in a non-competitive manner between medical clinics, private practices and CLSCs. The Département régional de médecine générale (Regional department of general practice) will be responsible for proposing recognition of the sites to the Régie régionale.

3.7.4 The impact on information systems

The objective to establish a truly interactive network of services requires that the members be linked by information and communications systems which use a common language.

The choice of the network approach to ensure continuity of services and accelerate access is one of the fundamental orientations of the organization of services in the Montreal region. The success of such an approach requires maximizing the exchange of information between institutions.

The choice of an approach involving benchmarking and integrated accountability based on results requires adequate information systems in order to develop and produce indicators which can be used to provide reliable evaluations in regard to the attainment of targeted objectives.

In the sector of information and computer systems, these choices for the future require that we revise:

- our approach;
- our priorities;
- our manner of planning and coordinating the development and management of systems;
- methods and levels of funding.

Our services to the population and our management activities require that we develop and implement systems designed for service networks rather than systems designed according to categories of institutions isolated from each other. The network concept is equally as to improving services to the population as it is to modernizing administrative and support services.

Our objectives for the future are to:

- facilitate networking to ensure continuity of services and rapidity of access;
- make sure that adequate information systems are available so that results indicators can be produced;
- facilitate the citizens' access to services and information;
- support the priority measures in the Plan to improve services for 1998-2002 which call for improved information systems: laboratories, improved access to surgery, breast cancer screening, interactive networks.

Networking cannot be achieved by combining over one hundred information resource master plans on the regional level, each one designed by a different institution.

Instead, a coherent cascade of interrelated plans on the provincial, regional, sub-regional and local levels must be developed.

According to the principle of subsidiarity, the action initiative and decision-making must remain as close as possible to the local level, unless there is an added value or marked benefit in passing to the sub-regional, regional or provincial level.

To ensure efficiency and effectiveness, our approach must be oriented toward n inter-institutional cooperation in order to develop and support the same type information systems or systems shared by the network.

In view of the major changes in our environment on the provincial level in regard to information resource management, the new priorities which will be defined in this regard in the spring of 1998 and the objectives of the plan to improve services 1998-2002, we must adopt a new plan of action on a regional level.

This renewed plan of action must be shared by the regional network and coordinated with the project to modernize administrative and support services.

In concrete terms, implementation of the plan to improve services will also require the following actions:

UNAVOIDABLE PROJECTS

- Adapt computer systems and equipment to the year 2000
- Implement the social and health information highway in the Montreal region;
- Implement and support the use of Lotus Note for the transmission of information within the regional network.

ESSENTIAL PROJECTS

- Develop exchanges of clinical data concerning laboratories, radiology and diagnostic services and possibly pharmaceutical and therapeutic services;
- Develop and implement software to facilitate monitoring of waiting periods for access and case prioritization and activate procedures for the specialties retained in the Plan for 1998-2002:
  - cardiac surgery;
  - neurosurgery;
  - orthopedics;
  - ophthalmology;
- Adapt and introduce a tool to evaluate the pertinence of hospitalizations and hospital stays;
- Implement the information system on emergencies (SIURGE) in the hospitals; →
- Introduce the home-care service information system (SISMAD) and the clientele-information system (SIC) in the region's CLSCs;
- Implement the information system on transfusive and hemovigilance activities;
- Implement the information system on breast cancer screening (SIDCS);
- Implement the youth practice support system (SSPJ) and the youth integration project (PIJ);
- Joint development of information resources by the five ambulatory centres provided for in the Plan for 1998-200s;
- Introduce the telemedecine network.

Projects referred to as unavoidable are those that we must perform, independently of the specific objectives of the Plan to improve services for 1998-2002, whether they involve the passage to the year 2000 or the implementation of telecommunications to link our institutions and institutions in other regions together.

The projects referred to as essential are those that we must perform if we wish to attain the specific objectives targeted by the Plan to improve services for 1998-2002.

In addition to these unavoidable and essential projects, other systems may be added, depending on new provincial priorities or projects related to the modernization of administrative and support services. These projects must be provided with special funding.

In the consultation support paper, we estimated the additional marginal expenditures necessary on a regional level at $9M over three years in regard to non-recurring investments. We also estimated that the regional recurring budget must be increased by approximately $3.3M per year to be assigned to information systems by the institutions.

Following the public hearings and the revision of the projects, we estimate additional non-recurring investments required at the regional level at $15M over four years. The portion of the recurring regional budget assigned to information resources must be increased to $4M.

The total cost of investments required on a non-recurring basis is $120.7M based on most recent estimates.

Of this amount, $42.5M will be required to adapt data processing systems and equipment to the year 2000. Funding for this project must be assumed by the Department's Capital Plan. In addition the $10.5M necessary to establish the

systems necessary in the five ambulatory centres must be included in the capital funding for these centres. Lastly, an investment of $15M will be required in order to modernize laboratory services.

Funding of the balance of $53.7M necessary must come from the Department's Three Year Capital Plan for information systems. Current estimates, which take the Department's priorities into account, allow us to hope for approximately $38.7M from this source, particularly for the implementation of:

- the information system on the CLSC home-care services (SISMAD) and clientele information systems (SIC);
- the information system on professional and hemovigilance activities;
- the breast cancer information system (SIDCS);
- the youth practice support system (SSPJ) and the youth integration project (PIJ);
- the telemedecine network.

Additional investments required to perform the regional plan of action come to $15M for the next three years.

In regard to recurring costs, our estimate takes into account the announcement of funding by the Minister of the costs related to the health and social service highway.

3.7.5 Impact on financial resources

The performance of the Plan to improve services for 1998-2002 will require development budgets and reallocations involving transfers of human resources, budgets and clienteles.

The financial implications are summarized in table 28 and 29 on pages 96 and 97 respectivally:

Table 28 - FINANCIAL SUMMARY OF DEVELOPMENTS AND REALLOCATIONS RELATED TO THE SERVICE CONTINUUMS

Scenario without development 1998-1999	Non recurring development			Recurring development				Reallocation				
	1998-1999	1999-2000	Total	1999-2000	2000-2001	2001-2002	Total	1998-1999	1999-2000	2000-2001	2001-2002	Total
Physical health												
3.1.12 Development fund for access to specialized and ultraspecialized services		12,964,600	12,964,600	10,177,800	16,655,600	18,732,600	45,566,000					
3.1.15 Improvement of post-operative and post-hospital care: CLSC services				1,060,000	2,120,000	2,120,000	5,300,000					
Sub-total		**12,964,600**	**12,964,600**	**11,237,800**	**18,775,600**	**20,852,600**	**50,886,000**					
The elderly												
3.2.1 Enhancement of 2,326 beds in CHSLD to 2.5 hr/care/day				3,600,000	7,400,000	7,400,000	18,400,00					
3.2.3 Increase in the rate of response				5,600,000	11,500,000	11,500,000	28,600,000					
3.2.7 Increase in CLSC home-care services				4 600,000	9,500,000	9,500,000	23,600,000					
3.2.9 Establishment of a day centre				300,000			300,000					
3.2.10 Increase in temporary placement services					300,000		300,000					
3.2.13 Addition of 400 non-institutional residential places								1,800,000	1,800,000	1,300,000	1,200,000	6,100,000
Sub-total		**12,964,600**	**12,964,600**	**14,100,000**	**28,700,000**	**28,400,000**	**71,200,000**	**1,800,000**	**1,800,000**	**1,300,000**	**1,200,000**	**6,100,000**
People with a physical impairment												
3.3.2 Intensive functional rehabilitation services in the home (CLSC development)				340,000	680,000	680,000	1,700,000					
3.3.4 Increase of $5.6M over three years to the POSILTH budgets in the 29 CLSCs				1,120,000	2,240,000	2,240,000	5,600,000					
3.3.5 Increase of $1M to the CLSCs for the program providing support to families				200,000	400,000	400,000	1,000,000					
Sub-total				**1,660,000**	**3,320,000**	**3,200,000**	**8,300,000**					

Table 29 - FINANCIAL SUMMARY OF DEVELOPMENTS AND REALLOCATIONS RELATED TO THE SERVICE CONTINUUMS

Scenario without developement 1998-1999	Non recurring development			Recurring development				Reallocation				
	1998-1999	1999-2000	Total	1999-2000	2000-2001	2001-2002	Total	1998-1999	1999-2000	2000-2001	2001-2002	Total
Mental health												
3.4.2 Integration and re-entry into the community												
- Services and resources in the community								1,800,000	3,600,000	3,600,000		9,000,000
- Adapted places in CHSLD								600,000	600,000			1,200,000
Basic mental health services									500,000	500,000		1,000,000
- Telephone access 24/7								1,000,000	2,300,000			3,300,000
- Basic CLSC mental health services												
Psychiatric hospitalization									600,000	600,000		1,200,000
- Enhancement of long-term beds in psychiatric hospitals												
- Creation of regional long-term beds (psychiatric hospitals)								1,800,000				1,800,000
Sub-total								**5,200,000**	**7,600,000**	**4,700,000**		**17,500,000**
Intellectual impairment												
Residential				1,160,000	2,320,000	2,320,000	5,800,000		1,757,252	3,514,504	3,514,504	8,786,260
Socio-occupational				600,000	1,200,000	1,200,000	3,000,000		184,173	368,173	368,346	920,865
Adaptation service and support for the person, the family and relatives (Rehabilitation centres)									418,575	837,150	837,150	2,092,875
Support to the family (CLSC)				460,000	920,000	920,000	2,300,000					
Pervasive developmental disorders (autism)				180,000	360,000	360,000	900,000					
Sub-total				**2,400,000**	**4,800,000**	**4,800,000**	**12,000,000**		**2,360,000**	**4,720,000**	**4,720,000**	**11,800,000**
Social adjustment												
3.6.3.1 Adopt a regional intersectoral alcoholism and drug addiction plan for the island of Montreal				260,000	520,000	520,000	1,300,000					
- Methadone												
(*) Measures in the plan of action												
Sub-total				**260,000**	**520,000**	**520,000**	**1,300,000**					
TOTAL		**12,964,600**	**12,964,600**	**29,657,800**	**56,115,600**	**57,892,600**	**143,666,000**	**7,000,000**	**11,760,000**	**10,720,000**	**5,920,000**	**35,400,000**

(*) Funding of the plan of action by the multisectoral partners $3,673,305

3.8. TO SUMMARIZE: TWELVE CENTRAL MEASURES

1. Improve access to the following ultraspecialized services:
   - cardiac surgery
   - neurosurgery
   - orthopedics
   - ophthalmology
   - radio-oncology

2. Serve people with an intellectual impairment who are waiting for services.

3. Permanently solve the problem of congestion in emergency rooms.

4. Improve access to first-line medical care:
   - establish an integrated service network.

5. Improve laboratory services and access to specimen collection.

6. Improve the response to the needs of services for the elderly experiencing a loss of autonomy.

7. Improve access to out-patient intensive functional rehabilitation services.

8. Improve access for people with a physical impairment to services permitting them to continue to reside in the community.

9. Improve access to basic services and community-based services in the mental health sector

10. Develop a shared and mobilizing youth project intended for youth and their parents.

11. Adopt a regional intersectoral action plan concerning alcoholism and drug addiction.

12. Integrate effective prevention and promotion measures within each service continuum.

4

A GATEWAY TO THE FUTURE: MODERNIZATION OF ADMINISTRATIVE AND SUPPORT SERVICES

4.1 A NEW CONTEXT

The situation concerning human and financial resources has changed a great deal over the past few months. Following tabling of the budget, it was confirmed that our financial resources would be stabilized for the 1998-1999 period; nevertheless, the problem of responsibility for the system costs remains. The voluntary departure program liberated over 5,500 equivalent full-time positions in Montreal, representing total salaries of around $200M per year. Approximately 36% of these departures involved positions in support services and many are still waiting to be filled.

The decrease in cuts compared to previous years, combined with the success of the voluntary departure program allows us to consider reorganizing our administrative and support services with a view to improving efficiency. To do so, we must ensure that the payroll released by these measures is used in the most efficient manner possible. This also responds to the Department's request that all the regions present proposals in this regard. This approach would even be supported by a targeted capital program. We know that work is well advanced in other regions and it is important that Montreal-Centre take its place on the provincial level in order to benefit from this opportunity.

Concerns regarding quality cannot be disassociated from the pursuit of efficiency. The population and the clientele have clear expectations in this area and a general perception that cuts have decreased the quality of support services.

We also know that the more efficient we are in these sectors, the better able we will be to deploy resources to maintain a quality/price ratio which corresponds to our standards and to improve the other services to the population. We must find out if more savings are still possible and, if so, introduce the measures necessary to release these resources for reinvestment. In the current financial context, the creation of any maneuvering margin is welcome, whether it be to respond to the natural increases in expenses (system costs), contribute to restoring financial equilibrium or to reallocate resources to services provided directly to the population.

Over the next few months, we will be finding the answers to these questions and choosing the best solutions for the future, in order to realize as many savings as possible, while ensuring the quality of our services. Union organizations appear willing to participate, provided current jobs are protected.

4.2 ORIENTATIONS

The regional plan proposed is based on the following orientations:

- Meet quality standards in the health and social service sector and the expectations of the population in regard to food, cleanliness of linen and facilities and equipment performance;
- Rethink the organization of work by making the best possible use of the unique opportunity offered by the voluntary departure program;
- Preserve the public character of services and related jobs;
- Make our services more effective by benchmarking among ourselves and with the private sector in order to consolidate and improve the performance of the public sector;
- Achieve the maximum potential savings;
- Adopt an approach involving grouping, sharing, pooling, inter-institution exchanges, or service agreements on a multi-institutional basis;
- Encourage the attainment of the objectives of the Plan to improve services to the population for 1998-2002.

4.3 CHALLENGES AND OBJECTIVES

In 1996-1997, the sectors of food, sanitary maintenance, laundry, maintenance of facilities and general administration represented total annual expenditures of $842M (of which $766M were in public institutions), representing approximately 25% of our regional costs.

A preliminary analysis of the potential savings in each sector of activity has already been performed based on data for 1996-1997. In June 1998, financial and operational data for 1997-1998 will be available. We will then be able to begin by identifying how far we have come in regard to our first estimates so that we can set more realistic targets. We can

Table 30 - SECTORS OF ACTIVITY CONCERNED IN PUBLIC INSTITUTIONS Net direct costs 1996-1997 (millions)	
Administration	$225M
Food	$167M
Laundry - linen	$49M
Housekeeping	$100M
Facilities	$225M
TOTAL	**$766M**

already anticipate a significant reduction in the targeted objective, due to the impact of the voluntary departure program in 1997-1998.

Each of these sectors of activity has special characteristics which require an approach adapted to the demands of the service provided and, when applicable, the methods of production and distribution which influence the cost price and the quality.

4.4 A STRATEGIC CHOICE FOR THE FUTURE: COOPERATION BETWEEN INSTITUTIONS

Savings can still be achieved on the local level, and certain organizations need to make efforts in this area. However, achieving the full savings potential requires reorganization of work and external contributions which can no longer be based solely on the size of the institution. A multi-institutional group approach could generate considerable savings that cannot be achieved otherwise.

In regard to services to the population, the Régie régionale has already opted for an orientation which involves establishing an interactive network of locally independent entities. This choice will ensure the continuity of the services provided to the population and the optimum use of our resources, while retaining all the value and diversity of local cultures. The same general orientation has been retained for administrative and support services, as proposed in a study sponsored by the Régie régionale.

Guiding principles

The approach retained is based on the following guiding principles:

- Preferred mode of action: inter-institution agreements;
- Partner institutions will be responsible for the choice of means;
- Assessment of the results and not the processes;
- An overall assessment of performance and achievement of objectives according to all the resources of the group;
- Partnership between employers and employees;
- Savings to be applied to direct services to the population.

A solution for the future: encourage inter-institution agreements based on proximity of interest and territory

In order to put our approach into action and adopt the means of attaining our objectives, we propose coordinating shared activities according to territories. The basic concept for these groups is founded on:

- inter-institution agreements based on proximity;
- a client-supplier approach;
- a gradual learn-as-you-go implementation.

The respect of the principle of subsidiarity: in order for an activity to be approached at the level of the cooperative or the region, it must involve an added value that could not be achieved otherwise.

This model will not be applied immediately to private institutions under agreement which could, nevertheless, form an association on an individual basis with a public institution for a specific project which offers common advantages.

- The territorial approach is preferred since its features enable:
  - complementarity between partners and increased participation;
  - benchmarking between territories, encouraging continuous improvement of performance;
  - development of integrated business plans at the local, regional and territorial levels;
  - simplification of regional management of infrastructure projects;
  - the possibility of inter-territory projects, or projects of regional scope if there is an added value in doing so;
  - preservation of a sufficient critical mass to retain specialized expertise in certain fields.

In establishing a new formal or legal structure, there is no question of creating an additional administrative level on a sub-regional basis. The approach will result in agreements

concluded between partners involved in specific projects (e.g.: laundry, food services). The member institutions will be responsible for selecting the action strategy and means and will be accountable for the results. This means that difficult choices will no doubt have to be made in regard to various projects. The Régie régionale will provide concrete support for modernization projects proposed by groups and will encourage innovation.

Territories will be created according to groups of CLSC districts. Minor adjustments to the map originally proposed are still possible. This territorial approach applies only to administrative and support services and is in no way designed to be a stepping stone toward a territorial organization of clinical services or concealed mergers of institutions. The results expected of this approach are:

- the performance of joint projects;
- the creation of real savings which can be used to reinforce clinical services;
- the delivery of quality services within an approach focused primarily on the clients;
- the establishment of inter-institution contracts, including quality specifications.

4.5 A RENEWED DYNAMIC AND LEADERSHIP

In this field, as in direct services, we hope that the institutions will act as a true network. To support this trend, the Régie will be approaching administrative and support infrastructure projects in terms of budget and allocation of resources, as inter-institution cooperative ventures and no longer as projects for individual institutions. One of the Régie's important roles in this new context will be to support investments of all types required to modernize infrastructures in the territories.

Various regional tools may be developed or supported to facilitate the attainment of our objectives, including:

- regional and sub-regional focus studies;
- targeted capital projects.

Various cooperation tools may also be planned on a territorial level:

- feasibility studies;
- consulting services;
- computerized management systems.

The Régie intends to use the same general approach as it has employed in regard to information resources, by adapting it to the specific context of this sector. These elements may be taken into consideration and dealt with using the same regional and territorial coordination approach, based on the principle of subsidiarity.

The nature of these projects requires interaction at the regional level. The Régie régionale proposes an inter-territorial coordination which, when circumstances are favorable, will facilitate global solutions, harmoniously integrating proposals prepared at the territorial level.

4.6 FOLLOW-UP

The Régie régionale announced its preliminary orientations in the autumn of 1997 and sharing mechanisms have been introduced in all the territories. Sub-regional initiatives are also underway in regard to food and laundry. The year 1998-1999 will be devoted to gradually continuing this process and encouraging experimentation of the formula. A first joint evaluation of the model is planned for the winter of 1999 and any adjustments required will be made following the results of this evaluation.

5

THE HEALTH SECTOR : AN IMPORTANT ECONOMIC POLE FOR THE MONTREAL REGION

5.1 SITUATION AND PROBLEMS

Health industries represent an extremely important sector of economic activity in Quebec and particularly in the metropolitan region where they are concentrated.

Companies are involved in five different fields[35]:

1. Pharmaceutical industries

There are 30 transnational corporations in Quebec, 40 small and medium-sized pharmaceutical companies, 60 companies specializing in natural products and 13 clinical research companies.

In 1995, production in Quebec reached $1.87 billion with exports of $336.4M and imports of $638M.

This sector represents 13,000 jobs.

2. Health-related biotechnology industries

The principal activities in this field are research and development, manufacture of vaccines and biological products.

This industry is composed of some 40 companies employing close to 1,040 people, 665 of whom are in research and development. Their annual sales total approximately $250M, mainly in the field of diagnostic products (65%). Most firms in this sector are small corporations created as a result of research work performed by institutions in Quebec.

3. Medical equipment industries

This sector includes some 200 companies, most of which are small and medium-sized firms with their principal activity the manufacture of medical and hospital supplies, technical aids and medical apparatus and equipment.

It employs close to 4,000 people with total sales of $301M, with $120M assigned to operations. It fills 25% of domestic market needs, estimated at $600M.

4. Information technology industries

Goods and services in this industry include the equipment, software and services used to collect, process and transmit information in the health field:

- telemedicine services;
- teleconferences and long-distance consultations;
- distance continuing medical education;
- network applications;
- direct research;
- data-base management;
- information systems;
- processing information on medication.

5. Service industries

These are mainly small and medium-sized firms which offer services on a commercial basis, both in Quebec and elsewhere.

These services include health administration consultant services, management of institutions and facilities, continuing medical education and training in nursing and other fields, architecture and engineering, non-insured dental, ophthalmology and optometry services and supplementary private individual or group insurance.

A large part of the dynamism of these sectors of activity is the direct result of the dynamism and performance of the research and development sector, one of the key assets in the Montreal region, which offers:

- a concentration of high-quality research infrastructures linked with university hospital centres, affiliated centres and institutes;
- the presence of a large number of university institutions;
- highly qualified manpower;
- a favorable fiscal environment;
- a solid base in the pharmaceutics and technological sectors;
- the possibility of a unique synergy between the health

[35] Bureau du partenariat économique, ministère de la Santé et des Services sociaux, September, 1997.

industries and the computer, multimedia and telecommunications industries.

The development of health industries is an important issue in our region which could benefit in the long term from economic development creating stable and high-quality employment the potential and comparative benefits available are utilized to their fullest.

5.2 A PLAN OF ACTION TO ACHIEVE OUR POTENTIAL

5.2.1 The strategic plan of the Conseil régional de développement de l'île de Montréal

In September 1994, during consultations initiated by the Conseil régional de développement de l'île de Montréal on its proposed strategic development plan, the Régie régionale suggested adding the following items:

"Sector in progress, the development of health industries, in the field of specialized and ultraspecialized care as well as in regard to services to the clientele, particularly home care services, is a particularly important issue for Montreal.

The concentration in the metropolitan area of French and English university hospitals, combined with the presence of medical technology industries, competitive pharmaceutical industries and a concentration of research centres, are assets which facilitate the creation of a cluster of health-related firms with a market which could extend beyond provincial boundaries.

Even though this sector is the second largest employer in the region, achieving this major objective nevertheless requires that a number of conditions are met:

- A change in perspective allowing the health sector to be viewed as a potential for creation of wealth rather than as a sector solely generating expenditures;
- The creation of closer ties between various segments of activity and the development of a partnership between the institutions, corporations and workers, focusing on this development objective;
- Deregulation and participation by employers and unions encouraging the reconfiguration of the sector, particularly to create manpower mobility and adjustment in a field which is experiencing rapid technological change;
- Recognition by the other regions and by the Government, of the metropolitan role of the Montreal region in the field of ultraspecialized services for the benefit of the entire Province;
- Mobilizing initiatives on the part of the Régie régionale de la santé et des services sociaux, the Department and the Government;
- Adoption of a joint development strategy for the international market in regard to other North-American cities which are very active in this area, such as Toronto and Boston."[36]

5.2.2 The Health Committee Report - City of Montreal and the Ministère du Developpement de la Métropole

Following this, the Régie participated in various work groups set up by the City of Montreal in order to contribute to providing the region with a plan of action which would make these orientations a reality.

The City of Montreal and the Ministère de la Métropole established a Health Committee formed of some thirty specialists and decision-makers in the health environment, chaired by Mrs. Hélène Desmarais, Chairperson of the Centre d'entreprises d'innovation Montréal.

The Régie participated in activities which had two objectives:

1) To understand the dynamics of the health industry;
2) To propose actions liable to facilitate and accelerate development of the industry.

The Health Committee's report, prepared with the participation of the Groupe SECOR, was made public in August, 1997. It proposes a plan of action focusing on three objectives:[37]

1. Stimulate entrepreneurship

Success obviously depends on the desire of the industry leaders. They are the ones who must find business opportunities, evaluate the risks and attempt to impose their products, ideas and know-how. However, entrepreneurs are not alone in this race. If the general conditions have not been established, companies in the region will inevitably be out-distanced by competitors from elsewhere. The committee drew up five recommendations to support entrepreneurship:

- The governments must, unequivocally, recognize the importance and potential of the health industry, support its development and establish conditions to encourage its expansion.

[36] Régie régionale de la santé et des services sociaux de Montréal-Centre, Letter to the Board of Directors of CRDIM, September, 1994.

[37] SECOR, Make the health industry a first-class industrial pole for the Montreal region, August, 1997.

- The health network must universally support local industry in its development efforts. This can be achieved by encouraging domestic entrepreneurship, by establishing incentives for innovation and ensuring that the regulatory framework encourages the creation of alliances with entrepreneurs.
- The Government of Quebec must reconsider the demobilizing effects of the physicians' remuneration structure and immediately establish a remuneration schedule for telemedicine.
- We must increase management abilities. To do so, the committee asked for universities to adjust their teaching programs to risk capital institutions; to encourage researchers-leaders to improve their management skills; for industry leaders to practice a business watch to facilitate the work of managers; and for governments to be attentive to factors liable to facilitate the hiring and integration of strategic workers from outside of Quebec.
- Risk capital institutions, financial institutions and governments must ensure that corporations which have successfully started up have access to the capital necessary to finance their subsequent development.

2. Encourage innovation

The Montreal health industry will be even stronger if it manages to rapidly translate scientific discoveries into marketable technological innovations. This complex process requires special attention. The committee drew up nine recommendations which could improve these conditions:

- To ensure the availability of qualified manpower, research institutions, specialized medical institutes, university hospitals and corporations must define measures which could limit the brain drain, solicit the return of the best researchers and physicians and encourage scientific studies and careers in the health sector.
- To maintain a favorable training framework, the Government must ensure that the universities have sufficient funds to provide a sufficient bank of equipment employing the latest technology. The committee also encourages the universities to rapidly and in a structured manner submit their research infrastructure projects to the new *Fondation canadienne pour l'innovation*, in order to ensure they obtain their fair share of this $800M fund.
- Rules limiting the right of foreign physicians to practice must be reviewed so that university hospitals and specialized medical institutes can hire the best specialists in the world.
- The Government of Quebec must maintain a highly competitive fiscal plan for research and development and remain attentive to developments in the other jurisdictions.
- The Federal Government must, once and for all, agree to offer legal patent protection equal to that found in countries in direct competition with Canada, to ensure research and development centres in the pharmaceutical sector locate here.
- The entire network and health system must facilitate testing and experimentation phases and adopt an approach which encourages development agreements with manufacturers of medical equipment. University hospitals in the region must play a leading role in this regard by fulfilling their mission of evaluating technologies. Government departments with an economic vocation must also establish mechanisms to facilitate financing of these activities.
- The ministère de la Santé must establish a provincial fund to contribute to financing operating costs in the event acquisitions are part of a procedure to develop a new product or even in order to create a technological window for an innovative product.
- The Government must also facilitate and encourage the creation of research consortiums in the health field.
- Lastly, technology transfer must be improved. Universities must place more value on it by taking related activities into consideration when evaluating professors. Organizations responsible for technology transfers must universally promote such transfers and ensure that the organizations which could contribute to financing are visible and accessible on the university campuses. The linkage between the various partners involved in technological screening and mounting technology transfer projects must also be improved.

3. Develop the flow of industry outside the region

Foreign markets offer a very important development potential. Our entrepreneurs must know that they can count on effective and dynamic organizations, capable of accompanying and supporting their efforts to attract the human resources they need and break into new markets. In order to profit from new channels to these markets, the committee drew up six recommendations:

- Hospital institutions in the region must commence a reflection process on the deployment of international telemedicine services. The committee encourages industry entrepreneurs to play an active role in efforts to standardize and establish rules which will regulate the practice of international telemedicine.
- The committee recommends that industry leaders and

certain funding organizations (SGF, CDPQ, FSTQ...) should explore possibilities to consolidate, particularly in the medical equipment group. In particular, small companies must seek alliances with large multinationals which have the expertise and the networks required to ensure rapid and wide-scale marketing of new products.

- All services and expertise in health in Quebec must be taken advantage of in an integrated manner. To do so, it will be necessary to maximize collaborations between the network and the private sector in order to facilitate exportation of our hospital management expertise and encourage the creation of health service export consortiums which take into account the type of needs of the clients.
- The Government must profit from the creation of three university hospitals and their important comparative cost advantage over their American competitors to explore the possibility of attracting American clientele to our institutions depending on excess capacities. This exercise must also be used to review practices concerning services to hospital clientele.
- The Government and organizations concerned, particularly Montréal International, must adopt a global strategy to increase visibility of the region's industry abroad.
- Lastly, government organizations such as CIDA must be more sensitive to commercial opportunities for the health sector and offer greater support for our practitioners within multilateral organizations.

5.2.3 Bureau du partenariat économique (economic partnership bureau), ministère de la Santé et des Services sociaux

In July, 1997, the ministère de la Santé et des Services sociaux created the Bureau du partenariat économique (economic partnership bureau).

Objectives

- To coordinate the actions of the Department, the regional boards and institutions, with a view to supporting and encouraging the development of Quebec health and social service industries on the regional and provincial levels as well as outside Quebec.
- To participate in promoting the expertise of Quebec's health and social service industries' services and products.
- To contribute to the development of companies by facilitating enhancement of knowledge and technology transfers developed by the network of university hospitals and institutes, together with the Fonds de recherche en santé du Québec.
- To contribute to the preparation of government strategies for partnership with private industries with the objective of developing Quebec's health and social service industries.

The Bureau will act as:

- Coordination centre;
- Centre for strategic planning and prospecting foreign markets;
- Information clearing house;
- Networking centre for the performance of export projects;
- Project management centre;
- Technolo-watch centre.

5.2.4 The special contribution of the Régie and the regional network

In general, the Régie régionale supports the objectives and recommendations proposed by the Health Committee last August. In addition, it intends to work actively together with the Department's Bureau de partenariat économique and to participate, on a regional level, in the discussion and joint action mechanisms to be established:

- To support the acquisition and development of innovative equipment, using all the levers at our disposal: capital plans, Approvisionnement Montréal, plans of action prepared by cooperatives;
- To participate in establishing the network of regional partners in order to adopt a concrete strategy and a plan of action similar to those in competitors' environments: Minnesota, Boston.

More specifically, the Régie régionale intends to contribute to the implementation of the following recommendations of the Health Committee:

- To reduce regulatory and institutional constraints which limit experimentation and development of durable alliances between institutions and innovative companies in the region;
- To facilitate the testing and experimentation phases of new products. To do so, it will be necessary to:
  - adopt a flexible approach enabling and encouraging development agreements with manufacturers of medical equipment;
  - develop partnerships with organizations with an economic vocation facilitating financing of experiments and trials;
  - encourage university hospitals to exercise their mission to assess technologies by using the wide range of means available: technology platforms and showcases, experimental centres;
  - relax rules of financing in the case of agreements to

develop new products or create technology showcases for innovative products.

In addition, we will support steps designed to:
- ensure adequate remuneration for medical acts provided through telemedicine;
- develop the export of medical expertise, particularly through telemedicine;
- enable the recruitment in university hospital centres of the best specialists available on a world-wide scale;
- create health service export consortiums.

5.3 A MONTREAL NETWORK WORKING WITH THE INSTITUT NATIONAL DE SANTÉ PUBLIQUE

All countries, particularly underdeveloped countries, devote considerable efforts to improving their health systems. Quebec's public health system has an excellent international reputation.

As well as the marketing opportunities related to health industries, the Montreal region offers a critical mass of professional and technical resources working in the field of public and population health.

All the Montreal universities have professors and researchers affiliated to research teams and centres involved in the field of public health. There are also a great many professionals working in the regional network.

This imposing potential led to a proposal to create a public health network in Montreal, presented by a group of people from the Université de Montréal, including representatives responsible for social and preventive medicine departments, health administration, environmental hygiene and occupational medicine, the Groupe de recherche interdisciplinaire en santé (GRIS) and the Centre d'excellence en promotion de la santé; from McGill University, representatives responsible for occupational health and epidemiology and biostatics; at UQAM, professors from various disciplines, as well as representatives from the Régie régionale de la santé et des services sociaux de Montréal-Centre and the Direction de la santé publique

This network could be assigned a mission to mobilize the community (university and health and social service network) around a vision and a plan of action to accelerate Montreal's development as an international pole in public health.

The network favors the exchange of ideas and information to improve the knowledge of public health needs and problems in Montreal and to ensure more pertinent and effective interventions. These discussions may lead to more joint research projects involving university and practical environments, new opportunities for university teaching, an increase in the number of foreign students registered in the various public health programs and the use of Montreal's expertise in the Institut national de santé publique

More concretely, the three departments in the public health sector of the universities in Montreal, as well as the GRIS, the joint department of McGill University and the Public Health department in Montreal-Centre are working to set up a joint public health summer school for the summer of 1998. These groups are also preparing a joint promotion brochure on their regular programs with a view to creating a joint public health school at McGill University and Université de Montréal with the participation of the Public Health Department. This partnership is designed to be open and non-exclusive, seeking to develop even more comprehensive training programs which are more appropriate and attractive to the international French and English-speaking environment.

The creation of the Montreal network of public health is, in our view, a very important step for Montreal, for public health, for Quebec and our reciprocal missions, as well as for the participatory climate which has already been established. This network also has the potential to contribute to developing the role and presence of Montreal on the international scene.

6 HUMAN RESOURCES

6.1 SUMMARY OF ACHIEVEMENTS IN HUMAN RESOURCES

6.1.1 Highlights

The unprecedented magnitude of personnel movements created by the Plan to reorganize services for 1995-1998 posed tremendous challenges for the region. These challenges could not have been successfully met without the participation of all management levels in the institutions and the sustained efforts of all the salaried employees.

Table 31

"Attaining a new balance"	Salary reduction target 1995 - 1997	impact of reducing positions / salaried employees
Closings	$112M	3,541
Cuts in institutions:	$147M	4,038
- Service reorganization plan	$131M	3,604
- System costs	$16M	434
TOTAL	**$259M**	**7,579**

The programs established by the Régie régionale and the approach adopted toward manpower redeployment and employee relocation were very effective and enabled us to move up the target dates for manpower financial objectives under the reorganization plan. As at March 26, 1998, of the 7,579 salaried employees with job security laid-off as part of this plan, only 418[38] were still registered with the Service régional de main-d'oeuvre. This means that as at March 26, 1998, 94.5% of laid-off salaried employees with job security had found a permanent solution to their employment situations.

Table 32

Plan to reorganize services	Salary reduction target	Impacts of reducing positions / managers
Closings	$16.1M	231
Cuts in institutions	$24.2M	425
TOTAL	**$40.3M**	**656**

[38] Excluding priority salaried employees (2 years of less seniority) of whom there were 55, as at March 26, 1998

As at March 26, 1998, of the 656 managers laid-off following hospital closings and budget reduction plans, 267 continued to have job stability and access to certain support programs and activities provided by the Régie régionale. This means that, as at March 26, 1998, 59.3% of managers registered had expressed a satisfactory choice in regard to their professional future.

Among the determining events of this transformation on the human level, the introduction of the voluntary departure program was a true keystone. Two of these programs were implemented at the Régie régionale's initiative and enabled the departure of 2,471 salaried employees. They also required non-recurrent investments of $54.3M and released a total payroll estimated at $90M. The impacts are significant since, in particular, they enabled considerably greater human impacts to be avoided, reduced the cost of the transformation within institutions and speeded up the actualization of recurrent savings in total salaries, targeted by closing institutions.

In addition to these regional programs, the Government's voluntary departure program involved 5,734 salaried employees and 255 management employees. This program cost $46.8M in assisted departure measures as well as $3.5M in separation pay and released a total payroll of $231.6M. (See table 33 on the following page).

Participation in the Government's departure program surpassed the 85% target initially set for the region. In addition to the 2,471 departures achieved through regional programs and the 1,308 departures performed through normal attrition in the network, the additional and unanticipated departure of 5,734 salaried employees places the region in an extremely difficult position in regard to maintaining a balanced workforce.

While sensitive to the many causes and impacts of this massive

Table 33

JOB CATEGORIES	Salaried employees as at March 31 [39]	Aged 50 y. or more [40]	% eligible [41]	Reduction target [42]	Number of departures [43]	% of total [44]	Deviation vs target [45]
	POTENTIAL POOL AND DEPARTURE TARGET (PERSONS)				COMFIRMED DEPARTURES AT OCT. 31, 1997 (PERSONS)		
Professionals	6,979	873	7%	212	253	5%	41
Nurses and graduate nurses	20,069	2,801	22 %	674	1,176	21 %	502
Technicians, Social workers, Educators	11,819	1,121	9 %	272	541	9 %	269
Nursing assistants	4,164	901	7 %	218	493	9 %	275
Paratechnical	16,758	2,320	18 %	560	876	15 %	316
Office	10,655	1,743	14 %	419	946	16 %	527
Trades and support services	13,021	3 ,007	23 %	723	1,449	25 %	726
TOTAL	**83,465**	**12,766**	**100 %**	**3,078**	**5,734**	**100 %**	**2,656**

[39] Total number of salaried employees in the Montreal-Centre region according to job category.

[40] Total number of salaried employees aged 50 and over, per job category.

[41] Percentage of salaried employees aged 50 and over per job category versus the total number of salaried employees aged 50 and over.

[42] Reduction target per job category (column 3 multiplied by the total target of 3,078 individuals).

[43] True number of departures per job category as at September 5, 1997, in individuals.

[44] Percentage of departures of all departures (column 5 multiplied by 100 / total number of departures (5,374)).

[45] Difference between the departure target (column 4) and the true number of departures (column 5).

wave of departures, we must take the opportunities it offers in order to consolidate, adapt and develop our human resources in keeping with the orientations proposed by the Plan to improve services for 1998-2002.

6.2 THE MAJOR WORK ZONES IN HUMAN RESOURCES 1998-2002

A renewed vision of human resources management

- **New challenges in human resources:**

  The results of the Reorganization Plan for 1995-1998, the needs identified in the Plan to improve services for 1998-2002, the conclusions formed during the regional forum held on September 26, 1997, as well as the points raised during the public hearings in March of this year, confirm the challenges which will orient our actions for the years to come in order to support the tens of thousands of people who continue to demonstrate their commitment within the network.

First challenge: To develop a true network mentality among the human resources

This common challenge must lead the administrators of institutions and the Régie régionale to share in choosing a model which reflects the acceptance and respect of each individual as well as a true desire to advance, within a regional networking dynamic, toward the fullest local autonomy possible in the strategic and operational management of human resources.

Second challenge: To considerably improve the coordination of communications and joint action mechanisms among the human resources

In attaining our objectives we must place a priority on the quality of the information disseminated and on exchange and participatory mechanisms in order to facilitate the establishment of the solidarity essential to the advancement of certain projects.

Third challenge: To understand and act on the malaise felt by managerial personnel

In periods of profound change, managerial personnel have a key role to play. Their leadership, the values that motivate them and their spirit of solidarity in regard to the objectives and stakes are determining factors. Our

experience over the past few years has left a profound unease among our managerial personnel which tends to hinder the exercise of their roles and responsibilities. We will have to achieve a clearer understanding of this malaise, and act promptly.

Fourth challenge: To give meaning to regionalization in labour relations

Following the public hearings, we have understood that this fourth challenge will take a little more time. The added value of regionalization in labour relations cannot truly be perceived until decentralization becomes part of the institutions' experience. The Régie régionale endorses decentralization and will do everything in its power in order to support the institutions in performing their responsibilities in this regard.

These challenges form the background in the process to establish a renewed vision of human resources management in the Montreal-Centre region. Over the next four years, it will continue to serve as the framework as we initiate two major work zones in human resources. These work zones have certain features in that they:

- target real problems;
- aim for observable results;
- orient the choice of priorities and assignment of resources;
- emphasize regional issues.

6.2.2 Work zone: Enrichment of managerial personnel

- **The issues**

In 1998, the situation of managerial personnel in institutions in the region was characterized by:

- **A significant decrease in the number of managers:** As at April 23, 1998, the Montreal-Centre region had 3,665 managers, a management ratio which has become a major cause of concern in an environment with our management requirements.

Table 34

Executive managers	127
Senior managers	442
Middle managers	3,096
Total	**3,665**

Tableau 35

Hospitals	1,609	CLSC	224
CHSLD	918	CPEJ-CR	292
Rehabilitation centers	266	Others	48
Psychiatric hosp.	308		
Total			**3,665**

- **The emergence of new skills** in response to a situation undergoing change which modifies relations and influences management methods.

- **The vision**

The Régie régionale feels that it is especially important to point out the essential support provided by managerial personnel in managing institutions. Consequently, to meet these issues, the Régie régionale proposes the following orientations which were favorably received during the public hearings, particularly by management associations:

- Recognize and promote a strategic place for managers in organizations;
- Promote the mobility and employability of managers;
- Reorient management development on regional issues;
- Provide more support to organizations in dealing with problems related to managerial personnel;
- Work to facilitate the reassignment of managerial personnel with job stability;
- Take joint action with partners.

■ ACTION PRIORITIES FOR 1998-2002

Priority 1: Contribute to repositioning and enriching the role and status of managerial personnel

The need to redefine the manager's role is part of a reflective process, concerning roles and status, as well as management ratios, performance measurements, recognition systems and the support required to manage the current changes.

The need to promote a more positive perception of the managers position involves the recognition of the position of the manager in his organization, emphasized by concrete actions on the local, regional and even provincial levels.

To this end, the Régie régionale intends to:

- propose issues and actions for consideration by senior managers in the network to clarify the manager's role in the conditions prevailing in the network's organizations;
- put forward new initiatives and large-scale regional events to enrich the manager's role and to highlight

local initiatives in this regard.
- give careful consideration to the impact of regional financial investment in the area of managerial training and ensure that the contribution of managers in achieving the organizational objectives on the regional and local levels is well documented.
- provide more human resources to advise boards of directors in selecting executive directors and to facilitate the process, primarily by providing them with practical tools for identifying and evaluating skills, and by allowing them to draw on experiences in this crucial area from around the regional network.
- work with the community in considering the problem related to the recognition of managers and offer possible solutions.

Priority 2: Provide the region with a manpower and career mobility plan for managerial personne

In order to do this, the Régie régionale intends to:
- create and share with its partners, an up-to-date data bank on the situation of managerial personnel in the region: number, average age, job level, linguistic and territorial distribution, costs, etc.
- propose various measures to promote the concept of mobility and facilitate its application. When working with partners, this will consist in professional internships at different institutions, measures to promote tutoring, sponsoring or mentoring, building networks of contacts, etc.
- focus development efforts on sustaining the anticipated changes in current managers and to prepare the next generation of managers. Some major initiatives are already underway: job development "Gestion des ressources humaines" and the program "Competency 2000". These initiatives will require extraordinary regional efforts over the next year.
- strengthen the link between development investments and the needs related to regional priorities, such as networking between institutions, the impacts of managing infrastructure modernization and consolidation of the transformation of the network.
- improve the distribution of information about jobs available in institutions and the profile of managers in the region requiring reassignment. More attention will be paid to needs for adjustment and retraining for laid-off managers. Thorough monitoring of the jobs-available situation and the clientele seeking employment could also help in matching supply to demand.

  The Régie régionale proposes working together with management associations and the institutions' administrations and intends to create conditions on the regional level which will encourage them to fulfill their roles in achieving action priorities.

  N.B. The Régie régionale also intends to pay special attention to the situation of non-unionized bargainable employees and to include them in the work zones. These employees have significant concerns, particularly in areas such as job security and provincial training budgets.

1.2.3 Work zone: Professional mobility and skill maintenance

- **The issues**

  Regional coordination of manpower movements and skill maintenance is determined by the configuration of our network of institutions, the extent of these manpower movements and the interdependency delineated in collective agreements, particularly in regard to job security.

  The provincial context in which our role and responsibilities are determined, too often results in tools and methods of exercising this role which do not necessarily reflect the situation in our region.

- **The vision**

The message which emerged during the public hearings confirms that the players in the health and social service network recognize the role of the Régie régionale in regard to:
- regional coordination of professional inter-institution mobility;
- support to institutions in maintaining a regional pool of qualified manpower.

■ ACTION PRIORITIES FOR 1998-2002

Priority 3: Provide the Montreal-Centre region with an authentic regional manpower plan

To this end, the Régie régionale intends to:
- complete the analysis of the socio-occupational profile of human resources according to major sectors of activity and identify trends.;
- anticipate fluctuations in manpower supply and demand; identify needs and problems;
- create and lead an inter-union advisory committee (a similar committee already exists for the FSSS/CSN);
- produce and disseminate, working with the community, a reference document on the management values promoted within the network in regard to professional mobility.

Priority 4: ***Improve professional relocation and mobility conditions within the region***

To this end, the Régie régionale intends to:

- separate the Service régional de main-d'oeuvre (S.R.M.O.) from the permanent structure so that, in keeping with the spirit of the official description, it serves as a mechanism representing the institutions;
- propose the establishment of an inter-regional joint-action committee with the Montérégie, Laval, Lanaudière and Laurentian regions. This committee would:
  - situate our mutual concerns in a larger context through the exchange of information on program orientations and the ensuing impacts;
  - identify common problems and build alliances;
  - develop operational mechanisms for co-ordinating replacement cycles as well as for anticipating and settling any resulting conflicts.

Priority 5: Support the administrators of institutions in their efforts to maintain the skills of their personnel

To this end, the Régie régionale intends to:

- develop training opportunities for instructors on a regional basis, to increase the independence and skills of institution managers in determining the training needs of their personnel, choice of training methods and evaluating the results of the training;
- develop indicators for the region that would provide for more rigorous evaluation of results with respect to the funds invested, especially as this applies to job requirements in reassigning laid-off personnel;
- follow the development of human resource operations within institutions in the network in order to identify the situation and problems experienced by human resources managers on the regional level.

N.B. During the public hearings, practitioners expressed reserve in regard to the solutions proposed. We believe that these reserves are based on an incomplete understanding of the situation and we intend to continue discussions in order to promote acceptance of the project

6.2.4 Labour relations, organization of work, mobilization and enrichment of human resources

In the initial consultation paper the Régie régionale had proposed two additional work zones. One concerned labour relations and organization of work and the other focused on the mobilization of human resources. These work zones represented a unanimous desire to orient our efforts toward a renewed vision of human resources management.

However, during the recent consultation and the public hearings it became clear that it is premature for the Régie régionale to exercise regional leadership in this area. In fact, if the Régie régionale is to interact within the current legal and institutional framework, there must be widespread consensus in this matter on the part of the milieu.

Contrary to our initial perception, it is clear that this unanimity does not exist in regard to the expectations concerning the role that the Régie régionale should assume in human resources management.

Consequently, the Régie régionale is withdrawing these two work zones and will orient its role to support the institutions. The Régie intends to offer its contribution in bringing together facilitating conditions that will enable the milieu to exercise local leadership in these areas of responsibility, subject to the skills for which it has already been recognized in the fields of planning, mobility, and regional manpower development. This means that mechanisms must be conceived with the milieu so that the Régie régionale can express its concerns on these topics.

During a regional forum, institution managers and their representatives made a tangible contribution in identifying the main problems concerning labour relations, organization of work and mobilization of human resources. They also endorsed the vision communicated by the Régie régionale of these problems. For this reason, while recognizing local leadership in regard to these problems, the Régie régionale will remain attentive to developments in the situation and, if necessary, will re-evaluate the contribution it should make.

- **Means of action 1998-2002**

To this end, the Régie régionale proposes that it:

- participate in and use the joint-action human resources committee established by the milieu;
- explore with the milieu, methods of exercising its role in regard to the mandates it has been assigned by virtue of collective agreements in the fields of planning, mobility and regional manpower development;
- establish a regional documentation and reference centre on litigation concerning job security and manpower planning clauses;
- provide a regional fund to study and document certain problems concerning labour relations and support institutions in seeking innovative solutions;
- create a regional information and discussion forum concerning current experiences in organization of work;

- provide the region with a diagnostic tool on mobilization of human resources:
  - Develop human resource mobilization. indicators with and for the milieu;
  - Carry out a regional survey on personnel mobilization and plan a schedule to repeat the survey regularly in order to objectively assess deviations and their causes;
  - Inform the milieu on the results of the surveys and their analyses;
  - Participate in the solutions explored by the milieu.
- Initiate a pilot project to produce the first issue of a regional human resource newsletter, with the contribution of human resources managers and articles from institutions' internal newsletters. This would:
  - provide the region with an information vehicle on manpower;
  - contribute to personnel enrichment by making local human resource programs and initiatives known;
  - inform the milieu of changes in human resource departments in the region;
  - provide information to the milieu on training and development programs;
  - provide information on the results of studies and research on human resources performed within the network.

Conditions for performance

We intend to prepare a detailed analysis of the funding required to implement the "two main work zones". However, we must immediately:

- Provide for certain costs, such as the following non-exhaustive costs, provided as an example:
  - The cost of training and re-training programs;
  - The cost of consultant and advisory services;
  - The costs related to intervention instruments and tools;
  - The cost of union leaves of absence;
  - The operating costs of advisory and parity committees;
  - The cost of settling litigation and arbitration at the regional level;
  - The costs related to transfer of personnel, manpower retraining, etc.
- Urge the institutions to encourage all their personnel to participate in the transformations.

For this reason, we feel it is necessary to reactivate the regional $3M adjustment and development budget which was temporarily assigned to financing transition costs and shared-cost departure programs.

To conclude, through the two main work zones and the means of action proposed, the Régie régionale intends to assume the proactive regional leadership it has been assigned in matters for which it is responsible. The Régie also wishes to reaffirm its support for the institutions and its desire to do everything in its power to reinforce their local leadership in the fields of labour relations, organization of work and mobilization of human resources. The timetable for the performance of these objectives covers a four-year period and its success is mainly dependent on the desire shown by the milieu to progress toward a renewed vision of human resources management.

7 FINANCIAL RESOURCES

7.1 FINANCIAL RESULTS FOR 1995-1996 TO 1997-1998

A review of the Reorganization plan for 1995-1998 shows that the budget reductions and reallocations proposed were implemented. With the completion of this first plan, we can now assess the financial situation of the health and social service institutions in Montreal-Centre.
This situation is not only the result of the decisions made by the Régie régionale over the past three years, but has also been created by Governmental and Departmental orientations and changes in the regional socio-economic environment, both of which were beyond our control.

An analysis of the effects of the budget reductions combined with the various shortfalls and phenomena causing underbudgeting experienced in the region allow us to estimate the recurrent outlay demanded of the Montreal health and social service network from 1995 to 1998 at approximately $600M. This amount can be subdivided into four main components:

- **Net reductions related to the Reorganization plan for 1995-1998:** According to the financial framework at the time, our net credits had to be decreased by $190M from 1995-1996 to 1997-1998. This involved average reductions of $63.5M for the three years, 1995-1996 to 1997-1998. While the real cuts applied were actually $64.1M (1995-1996), $60.4M (1996-1997) and $75.8M (1997-1998), for a grand total of $200.3M in three years, that is $10.3M more than originally planned. This included a special outlay of $41.8M in 1997-1998 related to the vast voluntary departure program.

- **The lack of financing of system costs:** The increase in the cost of supplies, salary increases and social benefits are examples of elements which result in an inevitable increase in the institutions' costs. The complete lack of funding experienced over the past three years resulted in total shortfalls of $162.6M from 1995-1996 to 1997-1998. These shortfalls had to be totally absorbed by the institutions, through various rationalization measures.

- **Overestimation of the level of certain independent revenues and underbudgetization of expense items:** The overestimation of the level of certain revenues such as room subsidies and other user contributions (non-residents, C.S.S.T. without contract, Federal government...) resulted in important shortfalls for several institutions. On the other hand, underbudgeting for certain specific services (medication program, catheters, defibrillators, for example) produced the same effect for a total of $40M from 1995-1996 to 1997-1998.

- **The volume effect related to increasing weight of clienteles and the increase in the population targeted for services:** This effect has been estimated at 1.8% per year by the Department, although no budgetary adjustment has been assigned. The impact over three years is estimated at $194.4M. It can be assumed that, for the most part, these services were actually provided, since we did not note any significant deterioration in waiting periods or increases in excessive stays in the emergency department during the period.

In 1998-1999, the regional network offered services with a budget of $3.1 billion instead of $3.7 billion, which would have been spent if the Reorganization Plan had not been initiated in 1995. In spite of this recurrent outlay of $600M, we have succeeded in reallocating $155M to develop services in certain key sectors, such as home-care and residential services.

If we examine the results obtained on the basis of expenditures actually made from 1995 to 1998, the reduction in our budget provided for total net reductions in expenses of $388.9M over three years. Deficits recorded during this period total $212.9M. Savings based on disbursements were therefore $176M, that is 45.2% of the objective. However, if we take into account the shortfalls which had to be absorbed, the true outlay in three years was $952.5M, representing 82.4% of the anticipated $1,156 billion.

Approximately 80% of the institutions are still showing a surplus, have balanced budgets or a slight budgetary deficit (less than 1% of their budget). The latter are essentially the residential and long-term care centres, CLSCs and rehabilitation centres. On the other hand, the three institutions with the most problems, alone, represent 60% of the regional net deficit. In our opinion, the situation therefore requires targeted interventions and close monitoring of the

financial situation of "high-risk" institutions. Realistically we can hope for a return to balanced budgets within three to five years for the institutions which are experiencing the greatest difficulties. This period could be shortened to between one and two years for the other institutions which are currently showing a deficit.

To conclude, three observations can be made:

1. The reductions and reallocations provided in our Reorganization plan for 1995-1998 have been achieved in spite of the fact that the financial outlay required of the region was higher than originally anticipated.
2. The general restoration of financial equilibrium is anticipated by the end of 1999-2000, with the exception of the CHUM, the MUHC, the Jewish General - Sir Mortimer B. Davis Hospital and a few others whose situation will nevertheless be considerably improved.
3. The regional accumulated deficit will continue to increase until 1999-2000. A general adjustment in this regard cannot realistically be initiated before 2000-2001

7.2 FINANCIAL REQUIREMENTS FOR THE SERVICE IMPROVEMENT PLAN FOR 1998-2002

The net financial needs for the 1998-2002 Improvement Plan are $44.3M in non-recurrent funds and $147.3M in recurrent budgets to fund service improvement priorities and the costs associated with information, communications and humans resource systems.

In addition, a portion of the plan will be self-financing through intra and inter-institution reallocations totaling $42.4M. In the non-institutional residential sector, mental health and intellectual impairment, a portion of the measures proposed consist of budget reallocations accompanied by transfers of personnel, clienteles and responsibilities.

Performance of the plan will require that we improve the efficiency of our network by the equivalent of $95M, the main component being the absorption of system costs estimated at $54.8M in 1997-1998. No funding for these costs has been announced by the Department yet.

Therefore, in terms of recurrent expenses, 48% of the plan will be self-financing on the regional level. Development funds of $147.3M required from 1999 to 2002 represent an increase in our budget of 1.6% per year. This is comparable to what other provinces, New Brunswick for example, achieved by reorganizing their health services during the 1990's. This increase is lower than the systemic effect of the aging of the population on the increase in expenses which was 1.8% before the reorganization of the network. *(See table 36 on the opposite page).*

7.3 OUTLOOK FOR DEVELOPMENT FUNDING

We are beginning to have a clearer picture of the budget outlook for fiscal 1998-1999. Our funding level should stabilize at around $3,070 billion. The Régie régionale is requesting a reduction in the burden of the 1998-1999 system costs. We can only hope for a reduction of this burden commencing in 1999-2000. The results of the next round of negotiations between the government and the unions is an unknown as well as being the determining factor in this regard. It is always possible that, due to the deterioration of the economic situation, a new wave of real cuts will prove to be necessary at the government level in order to achieve deficit zero by the year 2000. Annualization during 1998-1999 of the budget reduction related to the vast voluntary departure program comes to $15M.

A provincial envelope has also been planned, covering teaching, research, institutionalized services in mental institutions and ultra-specialized services. this closed envelope would be distributed between the regions which currently provide these services, that is, principally Montreal-Centre. Since no adjustment mechanism has been provided to meet additional demands, the intolerable situation of the past few years may well continue. Montreal-Centre must use its own resources to self-finance the response to a new and very costly need which concerns 50% of a non-residential clientele.

It appears that, on one hand, other than reallocations of resources, the prospects for self-financing non-recurrent and recurrent developments required by our Plan for 1998-2002 does not, at first sight, exist. On the other hand, additional savings which could be achieved by the modernization of administrative and support structures could result in tens of millions of dollars. In this case, the Régie régionale has, however, made a commitment that savings realized as part of the modernization of administrative and support structures by the sub-regions should be left to each territory, subject to a savings sharing model approved by the Régie régionale. In this case, we are essentially referring to potential savings which will take some time to deliver the anticipated benefits. These cannot therefore be considered as a reliable source of funding for the investments required in regard to direct user services. Intersectoral funding anticipated for certain measures (e.g.: alcoholism and drug addiction) also remains to be confirmed.

Another unknown is the rate of increase in expenses that will be assigned by the Department commencing in 1999-2000, to take into account the systemic effect of aging of the population on costs for the health and social service network.

This makes for a lot of "ifs" which is why we have to bring

Table 36 - PLAN TO IMPROVE SERVICES 1998-2002
Development budgets, reallocations, efficiency measures and other budget outlays planned

Financial summary

Category of measure / Measures	1 Non recurrent development 1998-2002	2 Recurrent development 1998-2002	3 Intra and inter-institutions reallocations 1998-2002	4 Efficiency improvements and others 1998-2002	5 Sources of funding suggested and comments
DEVELOPMENTS AND REALLOCATIONS RELATED TO THE SERVICE CONTINUUMS (1)					Funding to be confirmed for development
SUB-TOTAL	**$12,964,600**	**$143,666,000**	**$35,400,000**	**$ -**	
OTHER IMPACTS					
SYSTEM COSTS 1998-1999	- $	- $	- $	$54,800,000	Funding to be confirmed, otherwise development must be self-financed by each institution
VOLUNTARY DEPARTURES 1997-1998, ANNUALIZATION	- $	- $	- $	$15,200,000	The budget outlay related to voluntary departures 1997-1998. Affects all categories of institutions, except for the C.H.S.L.D.s.
EFFICIENCY OUTLAYS	- $	- $	- $	$25,000,000	Concerns the C.H.S.L.D.s and C.L.S.C.s within the scope of the continuum of services for the elderly.
INTERSECTORAL FINANCING	$7,600,000	$3,673,000	- $	- $	Partial funding confirmed.
INFORMATION SYSTEMS	$15,000,000	- $	$4,000,000	- $	Funding to be confirmed for developments.
COMMUNICATIONS PLAN	$8,700,000	- $	- $	- $	Funding to be confirmed for developments.
HUMAN RESOURCES	- $		$3,000,000	- $	Funding to be confirmed for developments.
SUB-TOTAL OTHER IMPACTS	**$31,300,000**	**$3,673,000**	**$7,000,000**	**$95,000,000**	
REGIONAL TOTAL	**$44,264,600**	**$147,339,000**	**$42,400,000**	**$95,000,000**	

about certain conditions on the provincial scale in order to move forward with the overall Service Improvement Plan for 1998-2002.

- Funding of system costs starting in 1998-1999;
- An adequate level of funding from the provincial budget to carry out improvement priorities in the area of ultraspecialized services. An alternative solution would be to bill user-regions on a prorate basis for the additional demand, commencing in 1998-1999;
- Adequate capital budgets for achieving the expected savings in the reorganization of administrative and support services. These additional needs are estimated at $20M per year for a period of 3 years;
- A funding strategy that is in step with the development objectives targeted in the area of information resources;
- Start-up funding from the Department or intersectoral partners to provide for the reorganization of services in the continuums other than physical health;
- An adequate level of funding to provide for manpower adjustment and development and the assumption of the interest on the regional debt at a higher level;
- A provincial envelope for teaching and research, enabling adequate funding for services, fixed assets and the purchase or replacement of the equipment necessary to support the mission of university hospital centres.

It is evident that this will require very strict management over the next few years. Otherwise, any maneuvering room that we may have will just be swallowed up. We have to adopt a very precise and systematic action plan so we can regain our financial stability as quickly as possible. This means that the first year of our plan, 1998-1999, will be one of transition, in which existing services will be consolidated and new orientations gradually established. In view of the current lack of funds on the provincial and regional level, granting significant development budgets to support these orientations must be put off until 1999 and later, with the exception of budgets funded through reallocations.

8 CONDITIONS FOR PERFORMANCE

One of the main issues of the Service Improvement Plan for 1998-2002 is to create, on the regional level, the conditions required for its fulfillment and to obtain, on the provincial level, the facilitating conditions required to achieve the targeted objectives.

8.1 CONDITIONS FOR SUCCESS ON THE REGIONAL LEVEL

8.1.1 A strong consensus in support of the targeted improvement objectives and the network approach

The first and most important condition is achieving a substantial consensus in the region in support of the service improvement priorities and having the partners buy into the implementation of the solutions most likely to achieve our goals.

Providing ourselves on the regional level with a clear, integrated, and shared vision of the objectives to achieve and interdependent means for implementation is essential to the existence of a true network guaranteeing access to the right level of services at the right time, and in ensuring the continuity of services to the public.

If we are to be successful, our administrators, management, personnel, and physicians must buy into the network approach, which is one of the key orientations of the Service Improvement Plan for 1998-2002.

Buying into the network approach is essential to most of the Plan's measures, both in terms of services to the public as well as administrative and support services.

If we only pay lip service to networking, the objectives targeting service continuity and efficiency will not be achieved and another approach will to have to be put forward because there is no getting around these objectives.

We're firmly counting on the network approach because we believe that it best fits the features of Montreal as a community. It will allow us to ensure better continuity of services to the public and make optimal use of our resources while preserving the richness and diversity of our local communities.

Before taking any action to implement this approach, we need to ensure that the following conditions are present:

Conditions for success of the network approach:

- Partners must buy into networking and an effective cooperation approach;
- The desire to ensure each component in the network has the appropriate level of resources and information in order for it to play its role effectively;
- The definition of common objectives and the introduction of indicators enabling the performance of the network to be assessed.;
- The introduction of interactive functional liaison mechanisms based on uniform standards of communications.;
- A partnership based on the equitable sharing of efforts and benefits;
- Pooling of resources when doing so would enhance effectiveness and efficiency

On the regional scene, if we want, we can create the conditions for success needed to implement a real network of services.

8.1.2 Informed and active citizens

The second major condition for success on the regional level is being able to count on the support of informed and active citizens.

Achieving our objectives requires that the public be involved beyond simple exposure to the media.

The nature of the objectives put forward in the Service Improvement Plan for 1998-2002 will require changes in the attitudes and behaviors of providers and the public. Both will continue to experience significant changes in the way services are delivered and received.

The orientations that we have been following since 1995 and

which have been preserved in the plan for 1998-2002 will increasingly require that clients in the health and social services sector be treated as active partners rather than passive consumers.

We will give priority to seeking lasting solutions that target the maintenance and development of autonomy for the individual and in the living environment.

We aim to elicit the participation of active, responsible, and unified citizens by providing all the services and support required in the community, with interaction between community organizations and specialized institutions.

This approach, which is complementary to the network approach, requires that:

- the public has access to relevant information in order to facilitate access to the network of services as well as involvement and participation in the changes;
- staff, physicians, institutions, community organizations, and partners have access to relevant information that make it easier for them to carry out their roles;
- these orientations be integrated into the implementation of our four works zones in human resources.

We also believe it is important to recognize and support the major contribution of the thousands of volunteers involved in the health and social sector.

Whether it be as members of the boards of directors of our institutions, community organizations, or members of foundations, users' committees or volunteer organizations, volunteer commitment is one of our most important assets and its contribution guarantees humane and equitable public services which are part of our common heritage.

Supporting this volunteer commitment means making the necessary information and support available to maintain and develop the participation of citizens in the life of their health and social service network.

An intersectoral partnership focused on action

Achieving our objectives in the various service continuums, especially in the sectors of social adjustment and mental health, requires the maintenance and development of an effective, intersectoral partnership focused on action throughout the region.

The conditions for success of this partnership are founded on:

- identifying shared priorities and common objectives;
- maintaining and developing the specific contribution of partners in supporting social and community development;
- creating and maintaining effective connections for action at the local and regional levels;
- the pursuit of financial consolidation of community groups.

The creation, by the Régie régionale, of a support fund for inter-sectoral joint action amounting to $1.4M annually falls within the perspective of creating conditions conducive to partnering in our region.

Partnership is also one of the ingredients essential to the achievement of the objectives proposed to make health industries an even more important economic pole in the Montreal region. Above and beyond the contribution we can make within the scope of our specific mandates, we are committed to actively participate in the mechanisms that will be set up to encourage discussion and joint action.

8.2 FACILITATING CONDITIONS ON THE PROVINCIAL LEVEL

The performance of the Service Improvement Plan for 1998-2002 also requires a certain number of facilitating conditions on the provincial level. These conditions fall into six themes, as outlined below:

Medical practice

- The adoption of amendments to the Act to enable the creation of the Département régional de médecine générale (regional department of general practice);
- The conclusion of an agreement with the Fédération des omnipraticiens du Québec permitting the establishment of an integrated network of general practice;
- The lifting of the decree by which new general practitioners wishing to set up on the Island of Montreal are subject to a 30% reduction in their remuneration rates;
- Methods of remuneration for medical specialists permitting the achievement of our objectives for improving access to services in the following sectors:
  - cardiac surgery;
  - neurosurgery;
  - orthopedics;
  - ophthalmology;
  - radio-oncology.
- Adjustments to the 1997-2002 objectives set by the Department in regard to medical staffing in the following specialties:

- anesthesia;
- nephrology;
- diagnostic radiology.

- Methods of remuneration facilitating telemedicine;
- Measures permitting the recruitment of the best specialists available on a world-wide level in university hospital centres and research centres.

8.2.2 Departmental orientations in the mental health sector

- The formal adoption of new orientations accompanied by the means to implement them;
- A transition budget to initiate the development of resources in the community and the adjustment of human resources before proceeding to the social reintegration of persons who have been hospitalized for a long period and the closing of a significant number of acute-care psychiatric beds;
- A five-year timetable;
- Methods enabling the increased involvement of general practitioners in the mental-health field and improved coordination with psychiatrists.

8.2.3 Deregulation

- The implementation of deregulation to enable the transition from centralized management focusing on the process to management based on results;
- The reduction of regulatory restrictions limiting experimentation of new products and development of durable alliances between institutions and innovative companies in the region in the health industry sector.

8.2.4 Human resources

- Further decentralization of bargaining to the local and regional levels;
- Relaxation of collective agreements in order to encourage manpower mobility and reorganization of work.

8.2.5 Financial resources

- Funding of system costs commencing in 1998-1999
- Adequate capital budgets to enable the anticipated savings to be achieved in the reorganization of administrative and support services. These additional needs are estimated at $20M per year over 3 years;
- A funding strategy in line with the objectives targeted in regard to developments planned in the area of information resources;
- Start-up funding from the Department or intersectoral partners to enable the reorganization of services in continuums other than physical health;
- An adequate level of funding for manpower adjustment and development and assumption of the cost of interest on the regional debt at the higher level;
- The composition of a national envelope for teaching and research enabling adequate funding of services, fixed assets and the purchase or replacement of the equipment necessary to support the mission of university hospitals;
- Identification of adequate provincial budgets to fund ultraspecialized services;

The creation of provincial budgets to finance these services would be a solution, on the condition that:

- all the costs related to these activities, particularly those involving research, teaching, administrative and support services are taken into account;
- a balancing fund is provided which will enable a balance to be maintained between the offer of services and needs and the respect of optimum waiting periods for access to health services.

The plan cannot be achieved in full without an injection of additional financial resources by the Department. Although the plan will be 49% self-financing on the regional level, its full performance requires recurrent development budgets of $147.7M for the period from 1999 to 2002. This would correspond to a budget increase of 1.6% per year, commencing in fiscal 1999-2000.

8.2.6 The establishment of an intersectoral plan of action for alcoholism and drug addiction

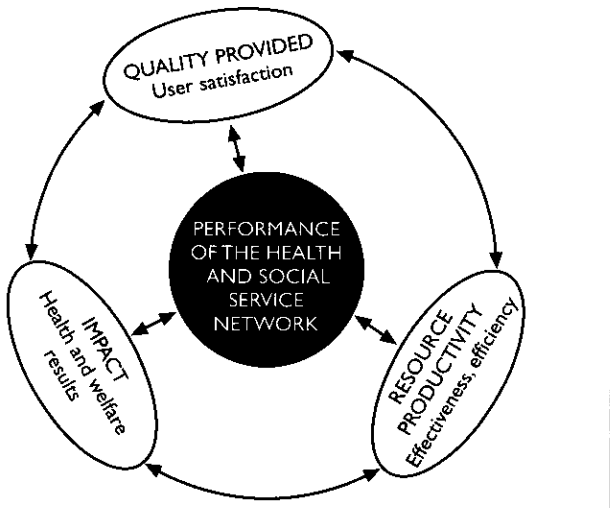
- Government leadership for the establishment of an inter-sectoral plan of action to deal with alcoholism and drug addiction mobilizing various government departments, crown corporations and partners from the private, union and municipal sectors

9 CONTINUOUS QUALITY IMPROVEMENT AND ASSESSMENT OF RESULTS

The Régie régionale has targeted three related goals within the scope of the Service Improvement Plan for 1998-2002:

1. The improvement of the health and welfare of the population;
2. The improvement of the quality of the response to the expectations of the population and user satisfaction;
3. The improvement of effectiveness and efficiency of services.

Table 37



The Régie régionale is responsible, on a regular ongoing basis, for evaluating the performance of the entire health and social service network with respect to these three complementary and interrelated means of action.

Furthermore, we need to implement continuing improvement strategies that will allow us to enhance the quality of our performance in all continuums of service and in all facets of our activities, whether they be services to the public or administrative/support services.

We are prepared to adopt a general, integrated approach to improve quality for all the institutions.

9.1 A CENTRAL TREND CHART

The follow-up of the Service Improvement Plan, using strategic indicators, is designed to provide fully integrated accountability based on results, which will enable the extent to which strategic choices in the plan have been implemented to be verified and allow decisions to be made as they are required.

Integrated follow-up requires that we implement a single tool for presenting results indicators for the following components: network efficiency and effectiveness, impact on health and welfare, and client/public satisfaction.

The central trend chart meets these requirements and, in the same model, provides indicators of service accessibility, development of priority services in the community, the impact on health and social services, modernization of administrative and support services, developments in the financial situation, manpower training in priority fields and user assessments of the services provided.

Table 38

RESULTS INDICATORS FOR THE PLAN FOR 1998-2002

Accessibility of services

1. Targeted surgical procedures[46] :
   a) in cardiology: average waiting period and number of users on the waiting list,
   b) in orthopedics and ophthalmology: number and percentage of users waiting for excessive periods.
2. Radio-oncology treatments: waiting periods and number of people waiting for certain targeted medical conditions[47].
3. Waiting period for intensive functional rehabilitation (certain medical conditions[48]).
4. Waiting period and number of people waiting for services concerning an intellectual impairment[49].→

[46] Targeted surgical procedures are as follows: all surgery in cardiology, implantation of total hip or knee prostheses in orthopedics and cataract surgery in ophthalmology.

[47] Targeted medical conditions are as follows: breast cancer, cervical cancer, lymphoma, ORL for pediatric clientele.

[48] Targeted medical conditions are as follows: cerebral vascular accident, implantation of total hip or knee prostheses, amputation of a limb.

[49] These services include those in residential environments, occupational environments, educational support and support to the family.

5. Waiting period for placement in a residential and long-term care centre[50].
6. Rate of response to requests for placement in a residential and long-term care centre[50].
7. Average length of stay in a general and specialized care hospital.
8. Ratio of users who remain on a stretcher for excessive periods[51].
9. Developments in the number of ambulatory visits to emergency rooms between 8 a.m. and 10 p.m.[51].

Care and services in the community

10. Developments in the number of users served in CLSCs following treatment in a general and specialized care hospital[52].
11. Developments in the number of elderly people served in their home by the CLSCs[53].
12. Developments in the number of users with a physical impairment:
    a) Developments in the number of users benefiting from the CLSC intensive home-care services;
    b) Developments in the number of users waiting for the CLSC's intensive home-care services.
13. Developments in the number of users receiving the CLSC's mental health services.
14. Proportion of users served by ambulatory psychiatric services.
15. Variations in the volume of youth clientele served jointly by centres jeunesse and the CLSCs.

Impact on health

for care dispensed in hospitals for certain medical conditions[54]

16. Admissions rate
17. Case fatality ratio within a three month period following admission.

in regard to access to first-line medical consultations

18. Number and ratio of avoidable hospitalizations.

Maintain and improve human resource skills

19. Developments in the hours assigned to retraining and continuous training.

Modernization of services and stability of the financial situation

20. Development of funding and working hours assigned to administrative and support services. →
21. Developments in budget reallocations.
22. Level of institutional surplus/deficits.
23. Level of institutional loans.

Users' point of view

24. Assessment of personnel competence.
25. Assessment of accessibility and continuity of services.
26. Assessment of the rapidity and ease of access of services.

9.2 IMPROVEMENT THROUGH ASSESSMENT

This trend chart is one of the means that enable us to evaluate the attainment of objectives targeted by the regional network.

The analysis of the results will make it easier to identify areas that need improvement and will help us to make adjustments along the way so that we can get as close as possible to the targeted performance standards and goals.

In addition to the trend charts, we will use other evaluation and follow-up methods:

- Regular operational follow-up of network performance, particularly through information systems concerning emergencies, placements, admission to services for the intellectually impaired, the waiting list for cardiac surgery, etc.;
- Population studies on user health/welfare status and satisfaction;
- Annual report on user complaints;
- Universal benchmark studies: pertinence of hospitalizations and hospital stays, productivity of administrative and support services, efficiency of services for the elderly experiencing a loss of autonomy in the institutional and home-care sector;
- Integrated assessment of specific measures and problems:
  - Develop a research program designed to identify the needs of the population in terms of mental-health services and assess the impact of the transformations on the population's state of health and welfare (measure 3.4.6);
  - Prepare a breakdown to analyze and compare investments, needs and results at the local level in regard to youth interventions (measure 3.6.1.7);

[50] According to the care-hour category required, depending on the determination of services during the last orientation registered in Info-Admission.

[51] In physical health and mental health.

[52] Including medicine and surgery cases.

[53] According to the average weekly hours of nursing interventions in home-care.

[54] The targeted medical conditions are as follows: hip fracture (surgery), cardiac insufficiency, myocardial infarction, CVA.

- Draw up a list of rehabilitation services focusing on social integration and develop a service organization model for adult clienteles with motor impairments (measure 3.3.7);
- Support testing of an innovative project for integrated services for the elderly experiencing a loss of autonomy (SIPA) (measure 3.2.17).

9.3 PURSUING A STRATEGY OF CONTINUOUS QUALITY IMPROVEMENT

During the 1998-2002 period, we will be continuing the implementation of an integrated continuous quality improvement strategy in all the institutions in Montreal.

This strategy will particularly focus on the following elements:

- **Universal benchmarking with the best practices**
  This approach will be generalized and systematically used throughout the continuums of services for the population and in analyzing the performance of administrative and support services in order to identify means for improvement.

- **Generalization of the continuous improvement program for user satisfaction throughout the regional network**
  Once the testing being performed in some 20 pilot institutions has been completed, we will generalize the continuous service quality and user satisfaction improvement program to cover all the institutions in the region and make the necessary tools available to them. The pilot sites have enabled adjustments to be made in ways of doing things for different target clienteles and categories of institutions.

  These tools include satisfaction questionnaires, data processing software, clientele approaches, improvement strategies, management methods and continuous training. These tools include satisfaction questionnaires, data processing software, clientele approaches, improvement strategies, management methods and continuous training. The service concept developed following the satisfaction studies performed in 1994 and in 1997 will serve as a framework to ensure regional uniformity.

- **Implementation of integrated accountability**
  We have retained this orientation in regard to following up the results of the Service Improvement Plan for 1998-2002. We will move in the same direction for institutional accountability. This means we will have to modify the annual reports and information systems in relation to the performance indicators that would allow integrated evaluation of the achievement of results in the areas of service effectiveness and efficiency, impact on health and welfare, and user satisfaction.

- **Introduction of an integrated strategy to develop skills and mobilize human resources**
  This strategy will be applied through the measures introduced concerning human resource development and training.

10 INFORMATION TO THE POPULATION

One of the conditions for the success of the Service Improvement Plan for 1998-2002 will be the quality, reliability and pertinence of the information issued to the population over and above their exposure to news which they receive through the media and advertising.

If we wish the population to participate actively in taking responsibility for personal health and welfare and to take part in the changes, regular and continuous personalized information must be made easily available: by telephone (particularly through Info-Santé-CLSC), in the home, in the community, at service centres, and especially through contact with service providers.

The goals that we wish to achieve in terms of information will be:

- to ensure that the population, as well as the personnel and physicians, are aware of the facts concerning access to the services available in the Montreal network;
- to reinforce new ways of using services and developing the individual's autonomy;
- to place a value on the skills of people working in the network and their endeavors in regard to quality;
- to establish a clear contract with the population in regard to our commitment to offer quality services.

Our specific objectives in terms of information will be:

- to facilitate access to the network of services at the right time, in the right place, and with the right service;
- to make all relevant information accessible to people working in the network to facilitate the accomplishment of their role;
- to provide the population with the tools required to increase their ability to take care of their health and welfare in an independent and active manner, participate in the services used, and ensure individual rights are respected;
- to clarify and communicate the commitments made by the network in response to users' expectations, the respect of their rights, and the performance standards which they can expect in terms of access to services;
- to inform the population of the results obtained and the extent to which service quality objectives have been achieved by making reliable indicators accessible;
- to reassure the population in regard to the accessibility and quality of services by providing objective, reliable, and regular reference tools.
- to improve the network's performance in services involving reception, information and the procedure for making appointments.

In addition to these general objectives, several specific measures in the Service Improvement Plan for 1998-2002 will require specific communications plans if we wish to achieve our objectives and encourage access to the new methods of providing services and the resources deployed for prevention and promotion.

This will be particularly applicable to the following elements:

- In order to be effective, implementation of an integrated network of first-line medical services will require that the public be informed of the service centres offering access to medical services from 8 a.m. to 10 p.m., 365 days of the year; the family physician concept must be promoted and access facilitated as well as ensuring access to medical services for individuals experiencing a severe loss of autonomy or who require palliative care in the home.
- The generalization of specimen collection on a walk-in basis in the 29 CLSCs on the Island of Montreal also represents an important change which will facilitate speedy access to services and must be communicated to the population.
- Achieving the objectives targeted in most of our health-promotion and disease-prevention projects will require communications activities that can reach the target populations: the fight against breast cancer, improving cardiovascular health, preventing alcoholism and drug addiction, etc.
- In the mental-health sector, measure 3.4.6 proposes the preparation of a regional communications plan to increase public awareness about the various problems related to mental health and to inform them about the services offered in the sector.

  The results targeted by this strategy are:
  - to improve the understanding of mental-health problems;
  - to reduce the social stigma associated with mental-health problems and enhance the potential of people who are its victims;
  - to promote the screening of risk situations.

- The introduction of a shared and mobilizing youth project will require a communications plan in order to reach the Montreal and local communities;
- The major reorganization of the range of services for people with intellectual impairments will require special efforts to ensure that they and their families are aware of the services available and how to access them.

To ensure that the public is adequately informed, over the next three years, we will have to implement a general communications strategy and well-integrated specific communications plans.

A communications strategy was prepared under the 1995-1998 Plan. One of its main objectives was to directly inform the population about access to services in the physical-health sector in both the regional and local networks: hospitals, Info-Santé-CLSC, CLSCs, and medical clinics.

Another issue was information for the elderly about the network of services offered for people experiencing a loss of autonomy: home services, day centres, day hospitals, residential resources, and the single-window approach.

To support the objectives of the 1995-1998 Plan, we have decided to invest $8M over three years, given the scope of the changes undertaken and the size of our population: 1.8 million people living in more than 900,000 homes in 29 CLSC territories.

Given the importance of consolidating the changes already made over the last three years and supporting those expected from 1998 to 2002 across our six services continuums, we plan to invest $2.2M annually over a period of four years, to carry out the communications plan required to achieve our objectives with respect to the general public and to specific target groups.