

PRIMARY CARE SERVICES ORGANISATIONAL MODELS AND THE POPULATION'S CARE EXPERIENCE

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Primary care services have undergone significant changes in Québec. It is in this context that a research project entitled "Accessibility and Continuity of Care: A Study of Primary Care Services in Québec" was carried out in two health regions in the province: Montréal and Montérégie (Pineault, Lévesque et al. 2004). The main goal of this project was to study the links between different primary care services organisational models and health care experience reported by the population. The study was conducted by researchers from the Population Health and Health Services team at the Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal (DSP) and Institut national de santé publique du Québec (INSPQ), as well as from the Centre de recherche de l'Hôpital Charles LeMoine. Numerous partners and other researchers collaborated in this study.

The objective of this summary is to describe the different primary care services organisational models, their principal characteristics and a few of their elements of performance. The summary is part of a series of reports produced by the team on primary care services organisational models in Québec and their influence on accessibility and continuity of care (www.santepub-mtl.qc.ca/ESPSS/production.html).

INTRODUCTION

The organizational data presented here issue from a large 2005 study of primary care offices and clinics in the regions of Montréal and Montérégie. A total of 665 primary care clinics were identified. A significant proportion of clinic accepted to participate in the study, with a 71 percent response rate (Hamel, Pineault et al., 2007).

A set of characteristics was used to describe primary care organisations; it was structured around four aspects: **vision**, that is, beliefs, values and objectives pursued by the organisation; **resources** available; organisational **structure**, which includes rules, regulations and governance; and lastly, **practices**, that is, mechanisms underlying the production of clinical activities (Lamarche, Beaulieu et al., 2003). We used a configurational approach to study the organisational forms of primary care clinics. Organisations were grouped together based on a large amount of information, which enabled us to thoroughly document each organisational model. Primary care organisations were classified into five well-differentiated homogeneous groups.

A second survey was conducted in 2005 among the adult population in both regions (n=9,206). It allowed us to document use of the adult population's regular sources of primary care and users' perceptions of the accessibility, continuity, scope and reactivity of primary care services, as well as the outcome of care (Levesque, Pineault et al., 2007). A nominal link was made between the results of the population and of the organisational surveys.

ORGANIZATIONAL MODELS FOUND IN MONTRÉAL AND IN MONTÉRÉGIE

Primary care medical clinics were grouped into five organisational models: four *professional* and one *community* model of organisation. The Table on the following page shows how the professional and community models differ by type of organizational governance: private and public. Moreover, the models vary based on the vision under which services are organised, the complexity of their structure, their capacity to integrate into the health system, and organisational practices.

Characterisation of organisational models for primary care (n=473)

ORGANISATIONAL DIMENSIONS		PROFESSIONAL MODELS				COMMUNITY MODEL 12%
		single-provider 37%	contact 14%	coordination 22%	integrated coordination 15%	
Vision	Accountability	Clientele	Individuals who present	Clientele	Clientele–Population	Population–Clientele
Structure	Governance	Private – Professional				Public
	Internal-external integration	Low–low	Medium–low	Medium–low	High–high	High–medium
Resources	Quantity and variety	Little	Average	Average	A lot	A lot
Practices	By appointment–Walk-in	Mostly by appointment	Mostly walk-in	Mostly by appointment	Mixed	Mixed
	Range of services	Restricted	Restricted	Average	Broad	Broad

1. *Professional single-provider model*

This model of organization accounts for 37% of clinics in the study. It comprises the offices of general practitioners who work essentially on their own. Their vision is based on family medicine, with organisational priorities being continuity of services and follow-up of regular clients. In general there is one physician per organisation, no nurse, low-level information technology to support clinical activities and no technical support centre on site. Occasionally, two or three physicians share the space but on the whole, their practices remain separate. For most of these clinics, medical visits are usually by appointment on weekdays and the scope of services offered is limited. By and large, these clinics have few formal links with other care providers.

2. *Professional contact model*

This model includes 14% of clinics. It stands out for its vision of health service delivery, with a focus on accessibility and on responding to short-term needs. Walk-in services are a major form of practice. Medical teams vary in size and often occupy space in buildings where medical specialists also have offices. Generally, group work and interdisciplinarity are not very developed.

3. *Professional coordination model*

This model incorporates 22% of clinics. Usually, two to six physicians form the medical teams, and a group work approach is more or less formalized. Priorities are geared toward continuity of services and follow-up

of regular clients, for whom visits are mostly by appointment. The range of services offered is relatively extensive and is supplemented by existing referral networks. Few formal links are established with other care providers.

4. *Professional integrated coordination model*

This model accounts for 15% of clinics and is distinguished by a structure that fosters cohesion among professionals and systemic integration. It is characterised by teams of caregivers composed of several physicians and nurses. Team work is formalised and the clinics usually share space with specialists and other health professionals. Walk-in clinics and consultations by appointment are both available and these clinics offer a broad range of services. Family Medicine Groups (FMG) make up about 35% of the organisations under this model. Over 90% of organisations that include FMG are included in this model.

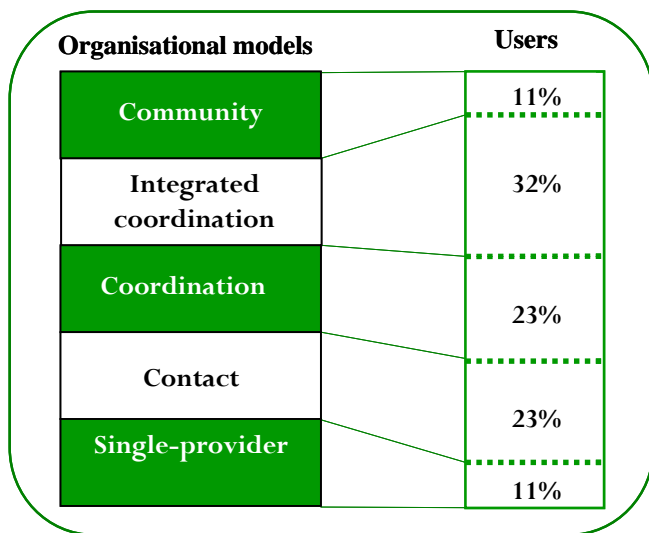
5. *Community model*

This model applies to 12% of clinics. Priority is given to continuity of care and accountability regarding the health of the population. Teams of caregivers usually consist of more than six physicians who formally work in a group, as well as nurses. This type of clinic often shares facilities with other health professionals. They offer a broad range of services, with both walk-in clinics and consultations by appointment. Organisations that follow this model are all integrated into public health structures such as CLSC and FMU.

WHAT IS THE REGULAR SOURCE OF PRIMARY CARE?

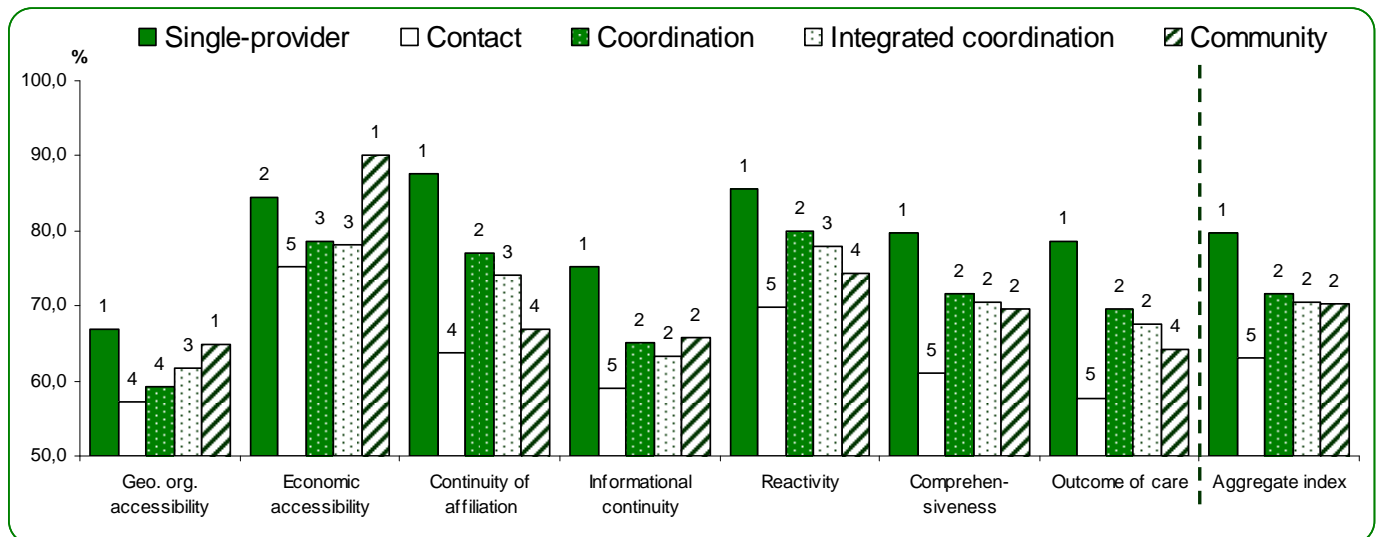
Organisations who have adopted professional models assume the largest part of primary care services in terms of population coverage. Indeed, these four professional organisation models serve almost 90% of users in Montréal and Montérégie, with organisations that have adopted the *professional integrated coordination* model serving the highest proportion of users (32%). On the opposite end, the *professional single-provider* and *community* models only reach about 11% of users respectively.

Proportion of users by regular source or primary care



Older people and poorer, less educated individuals make up a significant proportion of the clients of *single-provider*

Care experience indices by organisational model



clinics. *Community* model clinics have a high percentage of economically disadvantaged individuals, while a significant proportion of less-educated individuals go to *integrated coordinated* clinics. Overall, we note that organisations under the *professional contact* model serve lower proportions of vulnerable clientele.

WHAT DO USERS OF PRIMARY CARE SERVICES THINK?

Generally speaking, individuals gave favourable assessments of their health care experiences with their sources of primary care in both regions. The *professional single-provider* model ranks first in almost all aspects of the care experience, including geographical and organisational accessibility, continuity, reactivity and comprehensiveness, as well as care outcomes. These users' positive perceptions of their experiences are largely attributable to the special relationship that develops between patient and physician. Organisations that follow *coordination* and *integrated coordination* models are rated second highest, after the *single-provider model*, for most care experience indices. *Community model* organisations score ahead of all other models in terms of economic accessibility. Users also rate them favourably regarding geographical and organisational accessibility and informational continuity. Finally, the *professional contact* model ranks last in all dimensions of the care experience.

We should note that reports of unmet needs are significantly lower among users of organisations with *single-provider* models (14%) and high for the *contact* model (22%). Rates for the three other models are around 18%.

CONCLUSION

The adult population is served by primary care medical clinics that have adopted different organisational profiles. In the two regions studied, *professional* models, as opposed to the *community* model, serve 90% of users. Differences in perception of care experience persist among users of the various models. In the current context of primary care transformations, these issues certainly merit consideration. For example, although many people agree that the *single-provider* model is not the formula upon which primary care should be based in the future, the general population continues to assess it favourably. In addition, when implementing larger, complex organizations and networks, it is important to remember that the professional/patient relationship is at the core of care provision. Results also show that implementation of walk-in clinics alone is not a solution to accessibility problems. Finally, models that offer patient management and longer hours appear to be the best formula to ensure both accessibility and continuity. Our findings regarding organisational models are discussed in more detail in the research report (Pineault, Levesque et al., 2008).

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FINANCIAL SUPPORT

This study was funded by the Canadian Institutes of Health Research (CIHR), the Canadian Health Services Research Foundation (CHSRF) and the Fonds de recherche en santé du Québec (FRSQ). It also receives financial support from the Agence de la santé et des services sociaux (ASSS) de Montréal and Agence de la santé et des services sociaux de la Montérégie, Institut national de santé publique du Québec (INSPQ), Groupe de recherche sur l'équité d'accès et l'organisation des services de santé de 1^{re} ligne (GRÉAS 1), and Groupe interuniversitaire de recherche sur les urgences (GIRU).

September 2008

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Legal deposit – 3rd trimester 2008
Bibliothèque et archives nationales du Québec
Library and Archives Canada
ISBN: 978-2-550-53989-6 (Print version)
ISBN: 978-2-550-53990-2 (PDF)

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Centre de recherche de l'Hôpital Charles LeMoine (2008)