



## HIGHLIGHTS FROM THE DESCRIPTIVE REPORT OF THE POPULATION-BASED SURVEY OF CARE EXPERIENCES IN THE MONTRÉAL REGION

Odette Lemoine, Brigitte Simard, Sylvie Provost, Jean-Frédéric Levesque, Raynald Pineault, Pierre Tousignant

In 2005, the Population Health and Health Services team, a joint team from Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal and Institut national de santé publique du Québec, conducted a study in the two most populated regions of Québec (Montréal and Montérégie) to evaluate the association between primary care organizational models existing at that time and the population's care experiences. A second study was undertaken in 2010 to understand the evolution of primary care organizational models and how they have performed during the healthcare reform process, and to evaluate the organizational and contextual factors associated with these changes.

The study consists of three interrelated and hierarchically nested surveys:

- A population survey of adults randomly selected among the population of both regions to assess patient affiliation with primary care organizations, use of services, various attributes of patient care experience, preventive care received, and perception of unmet needs;
- A survey of primary care organizations to evaluate aspects related to their vision, structure, resources and practice characteristics, as well as primary care service reorganization;
- A third survey of key informants from Health and Social Services Centres to assess the organizational contexts within which various organizational models evolve.

This summary includes highlights of the population survey results on services utilization by the Montréal population, unmet service needs and the assessments of care experiences of respondents who have a regular source of primary care. Moreover, the values obtained in 2010 are compared with those for 2005. Detailed results are presented in the report, which is available on the Web sites of Direction de santé publique de l'ASSS de Montréal and Institut national de santé publique du Québec (addresses at the end of the document).

### Health services utilization in the past two years

The proportion of individuals hospitalized at least once

- increased from 14.6% in 2005 to 17.8% in 2010;
- increased in two CSSS territories between 2005 and 2010;
- in 2010, varied from one CSSS territory to another, from 13.0% (CSSS de la Montagne) to 20.7% (CSSS de la Pointe-de-l'Île).

The proportion of individuals who went to the emergency department at least once

- increased from 30.3% in 2005 to 35.4% in 2010;
- increased in three CSSS territories between 2005 and 2010;
- in 2010, varied from one CSSS territory to another, from 30.4% (CSSS de la Montagne) to 42.4% (CSSS Cavendish).

The proportion of individuals who saw a physician in a CLSC

- decreased from 22.1% in 2005 to 20.3% in 2010;
- in 2010, varied from one CSSS territory to another, from 11.8% (CSSS de Dorval-Lachine-LaSalle) to 28.3% (CSSS de la Pointe-de-l'Île).

The proportion of individuals who saw a physician in a medical clinic or private office

- remained stable at 79.1% in 2005 and 78.4% in 2010;
- between 2005 and 2010, increased in one CSSS territory but decreased in two others;
- in 2010, varied from one CSSS territory to another, from 72.8% (CSSS de la Montagne) to 85.7% (CSSS Bordeaux-Cartierville-St-Laurent).

### Family physician

The proportion of individuals who had a family physician

- increased from 64.1% in 2005 to 70.7% in 2010;
- increased in eight CSSS territories between 2005 and 2010;
- in 2010, varied from one CSSS territory to another, from 60.4% (CSSS Jeanne-Mance) to 77.8% (CSSS Cavendish).

### Unmet healthcare needs in the past six months

The proportion of individuals who had unmet healthcare needs

- remained stable at 18.4% in 2005 and 19.0% in 2010;
- increased in one CSSS territory between 2005 and 2010;
- in 2010, varied from one CSSS territory to another, from 14.6% (CSSS Cavendish) to 25.2% (CSSS Jeanne-Mance).

## Care experience in the past two years

**Methodological considerations:** The results in this section concern only service users who identified a regular source of primary care. Care experience at the regular source of care is assessed in terms of accessibility (first contact, economic, temporal and accommodation), continuity (of affiliation and informational), comprehensiveness, responsiveness, and outcome of care. Scores are obtained by summing responses to items that compose them, rescaled from 0 to 10. The higher the score, the more positive the assessment of the care experience is.

### Results by CSSS territory

The following table shows the scores for various indices measuring care experience by CSSS territory in Montréal as well as the changes observed between 2005 and 2010. The indices are defined below.

	Accessibility				Continuity		Comprehensiveness	Responsiveness	Outcome of care
	First contact	Economic	Temporal*	Accommodation	Affiliation	Informational			
Ouest-de-l'Île	5.2	7.9 ↓	51.5% ↓	6.6	8.7 ↑	7.7	7.8	8.7	8.3
Dorval-Lachine-LaSalle	5.7	8.8 ↓	44.4% ↓	7.0 ↓	8.8	7.6	7.8 ↓	8.7	8.4 ↓
Sud-Ouest – Verdun	5.9	8.7 ↓	33.2% ↓	7.3	8.4	7.4	7.9 ↓	8.7	8.4
Pointe-de-l'Île	5.6	9.0 ↓	43.8%	7.1	8.3	7.6	7.6 ↓	8.8	8.1 ↓
Lucille-Teasdale	6.0	8.8 ↓	39.0%	7.3	8.4 ↑	7.2	7.6	8.6	8.2
St-Léonard et St-Michel	5.9	8.6 ↓	35.9% ↓	7.0 ↓	8.3	7.3	7.5 ↓	8.7	8.0 ↓
Montagne	5.6	8.6	43.9% ↓	7.7	8.3	6.9	7.8	8.9	8.4
Cavendish	5.4	8.5 ↓	44.8% ↓	7.2 ↓	8.8	7.6	7.8 ↓	8.7 ↓	8.2 ↓
Jeanne-Mance	5.7	8.8 ↓	31.9% ↓	7.1 ↓	7.7	6.8	7.3 ↓	8.8	7.9 ↓
Bordeaux-Cartierville-St-Laurent	5.8	8.6 ↓	44.2% ↓	7.0 ↓	8.3	7.7	7.9	8.8	8.4
Cœur-de-l'Île	5.6	8.8 ↓	41.7%	7.3	8.0	6.8	7.3 ↓	8.7	7.9
Ahuntsic et Montréal-Nord	5.8	9.0	40.5% ↓	7.6	8.6	7.6	7.8 ↓	8.7	8.5
<b>Montréal</b>	<b>5.7 ↓</b>	<b>8.7 ↓</b>	<b>42.1% ↓</b>	<b>7.2</b>	<b>8.4 ↑</b>	<b>7.4</b>	<b>7.7 ↓</b>	<b>8.7</b>	<b>8.2 ↓</b>

↓ indicates a significant decrease between 2005 and 2010

↑ indicates a significant increase between 2005 and 2010

\* Results for a single item (and not a score) are presented to describe this measure. It indicates the proportion of respondents who could get an appointment with a doctor at their regular source of care in less than two weeks.

#### Definition of indices

**Accessibility:** A health organization is considered to be accessible if it can be easily used, that is, if there are few geographical, organizational, economic or cultural barriers to its use.

##### ▪ first-contact

This refers to first medical visit following the person's identifying a service need and seeking care.

##### ▪ economic

Good economic accessibility means that people do not have to pay fees to receive primary care services.

##### ▪ temporal

Only the distribution of respondents by waiting time for an appointment with the doctor is presented here to qualify temporal accessibility.

##### ▪ accommodation

This refers to ease of access to the source of care (e.g. adequate opening hours, ease with which a person can be reached by telephone).

**Continuity of affiliation:** This refers to stability over time of the relationship between the patient and professionals at the regular source of care.

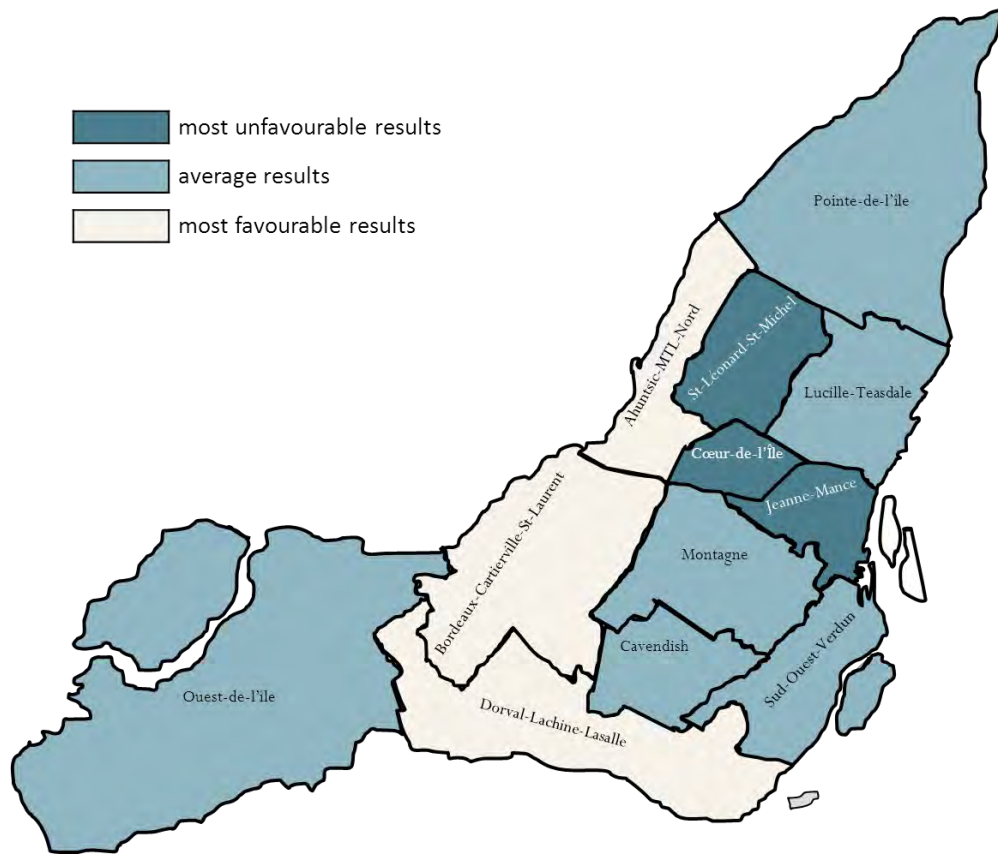
**Informational continuity:** This qualifies how information circulates between care episodes or among various sites where services are provided; it only concerns individuals who have had laboratory tests or who have seen specialists to whom they were referred by their physicians (about 40% of users of primary care services who have a regular source of care).

**Comprehensiveness:** This corresponds to all the services required to meet the majority of a community's everyday healthcare needs. It is generated by the availability of all services needed for a patient within an organization or by the assurance that other services are accessible in other organizations.

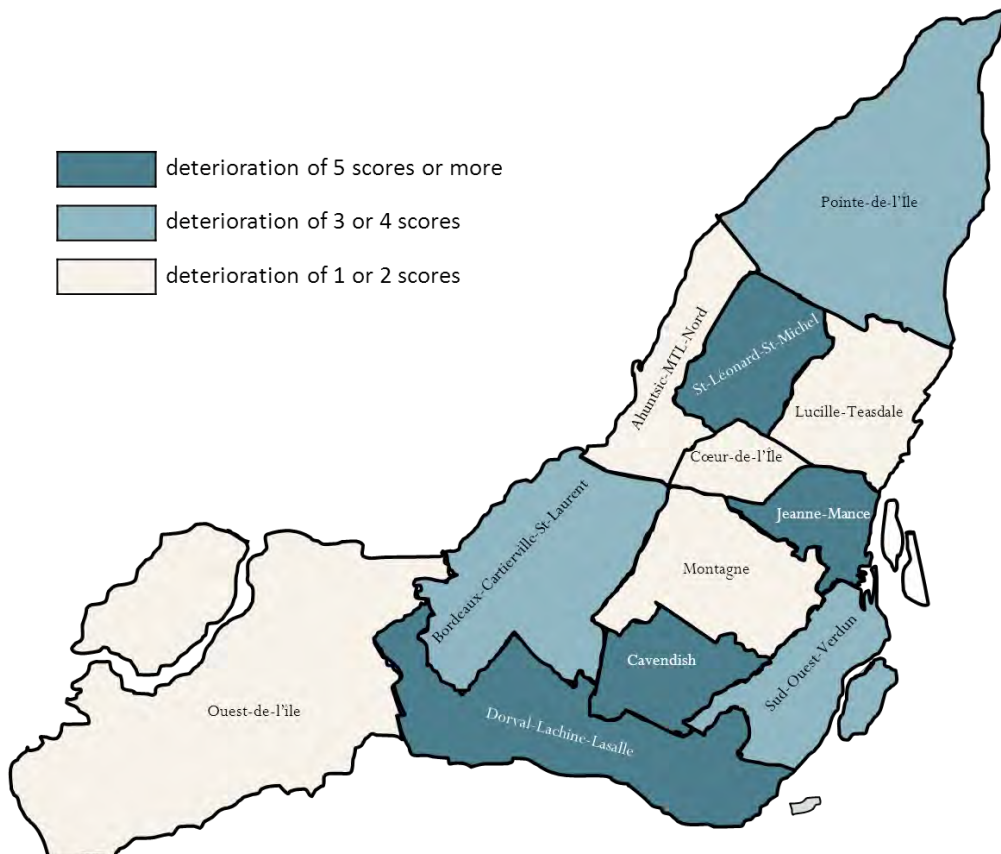
**Responsiveness:** This is defined as the response to a person's legitimate expectations regarding elements or actions unrelated to the technical aspects of treatment such as respect shown and attention given to patients.

**Outcome of care:** This refers to the effects or consequences of services on a person's health, as perceived by the individual. It includes perceived direct consequences on health as well as consequences on health-related knowledge, and intermediary results such as adoption of healthy behaviours.

**CSSS territory ranking by care experience score, Montréal, 2010 (weighted data)**



**CSSS territory ranking by number of care experience scores that deteriorated between 2005 and 2010, Montréal (weighted data)**



## Conclusion

In light of these results, we note an existing disparity between CSSS territories in Montréal relative to the evaluation of the care experiences of primary care services users. Thus, some CSSS territories have the least favourable results for Montréal (territories of CSSS du Cœur-de-l'Île, CSSS Jeanne-Mance and of CSSS de St-Léonard et St-Michel), while others have more favourable results (CSSS d'Ahuntsic et Montréal-Nord, CSSS de Dorval-Lachine-LaSalle and CSSS de Bordeaux-Cartierville-St-Laurent).

Moreover, we observe the same trends between 2005 and 2010 in a majority of CSSS territories as those outlined in the overall study results<sup>1</sup>. We can see that in half of CSSS territories, there are more patients with a regular family physician and greater loyalty to the regular source of primary care. However, accessibility to this source of care appears to decline in most CSSS territories. Only first-contact accessibility, which is less favourably evaluated, remained almost stable between these two years. In addition, we have noted a decrease in perception of comprehensiveness of services received as well as outcome of care received, again in a majority of CSSS territories.

Two territories stand out: The CSSS d'Ahuntsic et Montréal-Nord is not only one of the most favourably ranked in 2010 but it is also among the ones that posted the least deterioration between 2005 and 2010. The inverse is true for the territory of CSSS de St-Léonard et St-Michel: it is ranked among those with the least favourable results in 2010 and among those showing deterioration for five care experience indices or more.

Ongoing analyses on primary care organizational models will complete these data. They will enable us to better describe primary care organizational models in the Montréal CSSS territories and to determine the degree to which changes observed in care experience are attributable to changes in primary care services organization.

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<sup>1</sup> Lemoine O, Simard B, Provost S, Levesque J-F, Pineault R, Tousignant P, "Descriptive report of the population-based survey of care experiences in Montréal and Montérégie regions". Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal et Institut national de santé publique du Québec, Report of September 2011.

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This study was funded by Canadian Institutes of Health Research (CIHR) and Fonds de la recherche du Québec – Santé (FRQS) along with ministère de la Santé et des Services sociaux du Québec. It also receives financial support from the Agences de la santé et des services sociaux (ASSS) de Montréal and Montérégie, and from the Institut national de santé publique du Québec (INSPQ). The Fédération des médecins omnipraticiens du Québec and the Collège des médecins du Québec have given their support to the project.

The project has received ethical approval from the research ethics committee of the Agence de la santé et des services sociaux de Montréal, the main committee. The multicentre nature of the research project requires ethical approval from research ethics committees in each health and social services centre in the territories under study.

This document is available on the Web sites of the Direction de santé publique ([www.dsp.santemontreal.qc.ca/dossiers\\_thematiques/services\\_preventifs/thematique/sante\\_des\\_populations\\_et\\_services\\_de\\_sante/documentation.html](http://www.dsp.santemontreal.qc.ca/dossiers_thematiques/services_preventifs/thematique/sante_des_populations_et_services_de_sante/documentation.html)) and the INSPQ ([www.inspq.qc.ca/publications/](http://www.inspq.qc.ca/publications/)).

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