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Shaping Primary Health Care Teams and Integrated Care in Québec: An Overview of Policies (2000-2020)

Paul Wankah, *Université de Sherbrooke, Sherbrooke, Québec, Canada*
Mylaine Breton, *Université de Sherbrooke, Sherbrooke, Québec, Canada*
Alexandra Lukey, *University of British Columbia, Vancouver, British Columbia, Canada*
Isabelle Gaboury, *Université de Sherbrooke, Sherbrooke, Québec, Canada*
Mélanie Ann Smithman, *Université de Sherbrooke, Sherbrooke, Québec, Canada*
Marie-Élaine Malo, *Université de Sherbrooke, Sherbrooke, Québec, Canada*
Nelly Oelke, *University of British Columbia, Vancouver, British Columbia, Canada*

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Abstract

Primary Health Care (PHC) teams are an important component of the health system—particularly in terms of integrating care for vulnerable patients living with complex health and social needs. Over the last two decades, PHC teams have been implemented in different forms across Canadian provinces and territories. This article explores the health care policies that shaped the form and functions of PHC team-based care in Québec over the past 20 years (2002-2022). In Québec, the main model of multidisciplinary PHC teams—Family Medicine Groups or *Groupe de médecine de famille* (GMFs)—were created in 2002. In 2004, structural reforms led to the creation of local health networks (LHNs). LHNs promoted coordinated and collaborative activities between health and social services providers such as GMFs located in the same geographic regions. This was followed by another structural reform of the health system in 2015, leading to the creation of broader territorial health networks with the aim to heighten coordination and collaboration among provider organizations. Various policies have strengthened the PHC team-based model. For instance, the introduction of nurse practitioners, pharmacists, and social workers with extended scopes of practice shaped the configuration of GMFs while enhancing inter-professional collaborative practices. This article highlights important insights that could advance the understanding and creation of future PHC policy initiatives.

Les équipes de première ligne sont une composante importante du système de santé et sociaux—en particulier en ce qui concerne l'intégration des services pour les patients les plus vulnérables qui ont des besoins sanitaires complexes. Au cours des deux dernières décennies, des équipes de première ligne ont été mises en œuvre sous différentes formes dans les provinces et les territoires du Canada. Cet article explore les politiques de santé qui ont façonné la forme et le fonctionnement des équipes de premières lignes au Québec au cours des 20 dernières années (2002-2022). Au Québec, le principal modèle de première ligne—les Groupes de médecine de famille (GMF)—a été créé en 2002. Les réformes structurelles de 2004 ont conduit à la création des réseaux locaux de services (RLS). Les RLS ont favorisé des activités coordonnées de collaborations entre les établissements publics, les organisations privées, dont les GMF, et les organisations communautaires localisées sur les mêmes territoires géographiques. Cette initiative a été suivie d'une autre réforme structurelle du système de santé en 2015, qui a conduit à la création de réseaux territoriaux de santé et de services sociaux dans le but d'accroître la coordination et la collaboration entre les établissements. Diverses politiques ont renforcé le modèle d'équipe de première ligne. Par exemple, l'introduction d'infirmières praticiennes spécialisées en première ligne, de pharmaciens et de travailleurs sociaux ayant des champs de pratique élargis a façonné l'évolution du modèle des GMF tout en améliorant les pratiques de collaboration interprofessionnelles. Cet article met en évidence des idées importantes qui pourraient améliorer la compréhension et la création de futures politiques de santé de première ligne.

Key Messages

- The Family Medicine Group or *Groupe de médecine de famille* is the main PHC model implemented in Québec and is based on multidisciplinary teams of family physicians, nurses, nurse practitioners, social workers, pharmacists and other primary care providers.
- The evolution of the form and function of PHC teams reflects ongoing adjustments to changing public policies.
- Policies can provide a framework for action for PHC teams. However, more direction regarding integration and performance measurement is needed.

Messages-clés

- *Le Groupe de médecine de famille est le principal modèle de première ligne mis en œuvre au Québec et repose sur des équipes multidisciplinaires composées de médecins de famille, d'infirmières, d'infirmières praticiennes, de travailleurs sociaux, de pharmaciens et d'autres professionnels de première ligne.*
- *L'évolution de la forme et de la fonction des équipes de soins de première ligne reflète les ajustements continus apportés à l'évolution des politiques publiques.*
- *Les politiques peuvent fournir un cadre d'action pour les équipes de première ligne. Toutefois, il faut une orientation plus poussée en direction de l'intégration et de la mesure de la performance.*

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1 Introduction

The World Health Organization recommends strong Primary Health Care (PHC) as the foundation of an effective and efficient health care system (WHO 2020). The Patient-Centred Medical Home model has been promoted by the College of Family Physicians of Canada as a strategic priority for enhancing PHC and team-based care (Katz et al. 2017). Accordingly, multidisciplinary teams of providers working across professional and organizational boundaries are an important element of realizing effective PHC (Mulvale, Embrett and Razavi 2016; Pullon et al. 2016).

The composition and organization of PHC teams have evolved differently across Canadian provinces and territories. There is mixed evidence on the effectiveness and efficiency of team-based care as integration efforts are pursued in these jurisdictions (Hutchison et al. 2011). Furthermore, evidence is inconclusive on what policies and structures facilitate, incentivize, or prevent integrated service delivery through PHC teams, especially for vulnerable patients living with complex health and social needs. While previous work has described the Family Medicine Group (in French *Groupe de médecine de famille* and hereafter GMF) model and early policies related to the creation of GMFs (Pomey, Martin and Forest 2009; Breton et al. 2011), multiple changes in public policy with the potential to influence PHC teams and advance interprofessional integrated care have occurred over the past two decades (Katz et al. 2017). This article provides an overview of how these policies have shaped PHC team-based care and enhanced integrated care in Québec over the last two decades.

2 HISTORY AND CONTEXT

2.1 From Local Community Health Centres to GMFs

One of the earliest models of multidisciplinary PHC team-based care in Canada started in Québec in 1972 with the creation of Local Community Service Centres (*Centre Local de Services Communautaire*—CLSCs). The CLSCs were publicly funded and governed organizations wherein a variety of health and social services professionals (physicians, nurses, social workers, physiotherapists, nutritionists, etc.) provided a broad range of preventive and curative community-based services to their local population (Levesque et al. 2012). Major resistance from family physicians who were concerned about a reduction of their professional autonomy as salaried workers of CLSCs led to poor adoption of the model (Levesque et al. 2012). Although interprofessional collaborations within the CLSC model were reported positively by allied health professionals, there were concerns about inequity in its implementation—specifically differences in the package of services offered by various CLSCs across the province (Sicotte, D'Amour and Moreault 2002). Hence, successive ministerial commissions recommended important PHC reforms in Québec. For instance, the Rochon Commission of 1988 recommended the introduction of Regional Departments of

General Medicine as proximal governance structures that provided oversight, support and organized the activities of family physicians. The Clair Commission of 2000 recommended enhanced integration of health and social services as a means to reduce fragmented service delivery and also to improve the quality of health care (Levesque et al. 2012). The GMF model emerged as a response to criticism from the Clair Commission about the lack of integration between family physicians (solo and group clinics) and allied health providers, and previous failed attempts to convince family physicians to join CLSCs. Co-locating interprofessional teams in family-physician led clinics could improve access to and continuity of PHC. Figure 1 on the next page presents a timeline of key reforms and legislation in the evolution of PHC team-based care in Quebec over the past 20 years.

2.2 Models of group medical practices

GMFs are private group medical practices that were introduced in Québec in 2002. The GMF model consists of a group of approximately 6-12 independent family physicians who receive extra public funding to work in collaboration with nurses and administrative staff to care for the needs of enrolled patients. At that time, they were required to utilize an electronic medical record to facilitate interprofessional information exchange. Physicians in the GMF are mainly paid on a fee-for-service basis, but other resources, such as salaries for nurses and staff, are allocated to the GMF from the Ministère de la Santé et des Services Sociaux du Québec (MSSS) based on the number of patients enrolled. GMFs also receive public funding in exchange for services such as extended hours of operation (Breton et al. 2011). Thus, operating costs of private GMFs are carried by the contributions of family physicians and direct contributions from the MSSS. Two other complementary models of group medical practices exist—Network Clinics and University Family Medicine Groups. The Network Clinic model is a multidisciplinary group medical practice with enhanced hours of operation and technical platforms for diagnostic and therapeutic interventions (Levesque et al. 2012). This model has been implemented mostly in urban areas to relieve emergency room congestion and to provide population-based walk-in services. The University-GMFs are academic teaching units dedicated to training medical students and residents in primary care (Abou Malham et al. 2017). University-GMFs must be affiliated with relevant university programs and employ a quality improvement agent on their team.

2.3 Enhancing collaboration among PHC teams

In 2004, a deep structural reform led to the creation of 95 health and social service centres through administrative mergers of CLSCs, long-term care facilities, and some acute care hospitals. Each health and social service centre was required to implement local health networks (LHNs) in its territory to address the prioritized health and social needs of their geographically defined populations (Breton, Denis and Lamothe 2010).

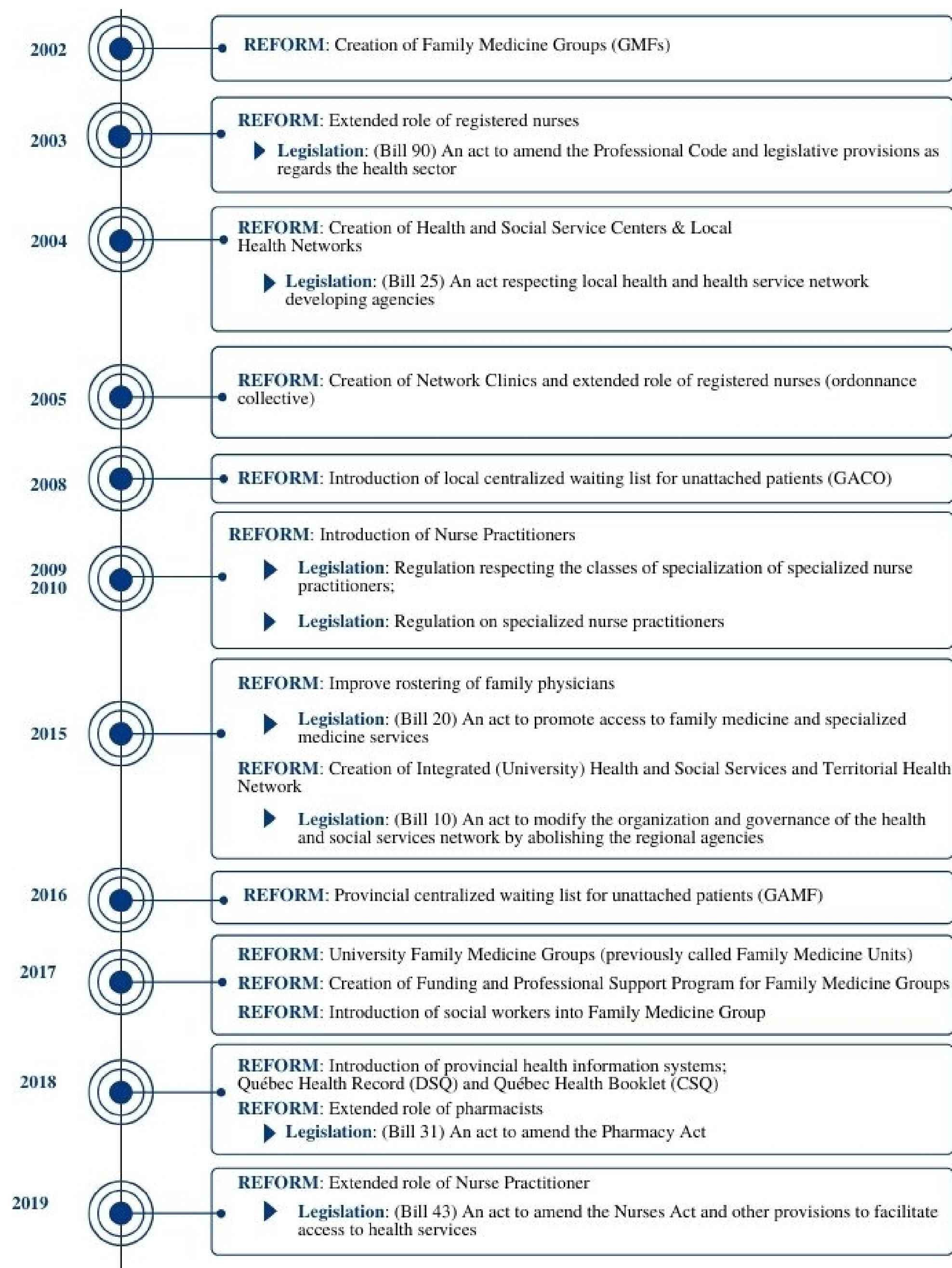

Figure 1: The evolution of PHC team-based care in Quebec, 2000-2020

These LHNs were positioned as a strategy to promote connectivity and collaborative team-based practices between the public sector (health and social services centres), the

PHC clinics (GMFs), and community organizations (Fleury 2006; Levesque et al. 2012). Another structural reform occurred in 2015 which created 22 Integrated Health and Social Service Centres through administrative mergers of neighbouring health and social services centres, bringing all public health care organizations under a single governance structure (Quesnel-Vallée and Carter 2018). The objective was to further enhance coordination and collaboration between provider organizations through broader Territorial Health Networks.

2.4 Transformation of PHC teams

The MSSS outlined specific missions for the various PHC team models. CLSCs aimed to establish a continuum of regular care needs, ranging from preventive, curative, rehabilitative and home care services, for their local populations. GMFs sought to improve access, continuity, comprehensiveness, and coordination of care through the enrolment of local populations to family physicians working with interprofessional teams. The extended hours of operation of network clinics were intended to improve population accessibility to PHC services while their enhanced technical platform allowed for better access to diagnostic and therapeutic services such as blood tests as well as specialized consultations such as geriatrics in order to reduce emergency visits. University-GMFs are focused on training the future workforce, promoting evidence-based care and innovations as well as research.

Successive policy initiatives changed the configuration and operations of PHC team-based care in Québec. In 2004, a major objective of LHNs was to enhance connectivity, collaboration and coordination of health and social services between provider organizations. In 2008, centralized waiting lists for unattached patients—the *Guichets d'accès pour la clientele orpheline* (GACO)—were implemented in various regions in order to simplify and facilitate access to a family physician. In 2009, the *Regulation respecting the classes of specialization of specialized nurse practitioners* introduced PHC nurse practitioners who are trained at the Masters level and provide care to local populations under the supervision of physician partners in GMFs (Brault et al. 2014; Contandriopoulos et al. 2015). Other health reforms progressively increased the competencies and scope of practice of nurses, nurse practitioners, and pharmacists in diagnostic and therapeutic procedures traditionally reserved for family physicians in order to improve access to PHC services from lower-cost providers. Legislation governing these reforms included an *Act to amend the Professional Code* and other legislative provisions regarding the health sector of 2003, An *Act to amend the Pharmacy Act of 2018* and *An Act to amend the Nurses Act of 2019*. In 2016, a new information system—the *Guichet d'accès à un médecine de famille* (GAMF)—was implemented to manage centralized waiting lists for unattached patients. The new system provided a single registration web portal for both patients and providers for the entire province, whereas these modalities had previously been administered by each region (Breton et al. 2015). In 2017, the MSSS created the Funding and Professional Support Program for Family Medicine Groups which aimed to foster PHC team-based practices by supporting social workers and other allied health care providers in GMFs (Wankah et al.

2018). The Québec Health Record (*Dossier Santé Québec*) was a provincial tool implemented in 2018 to collect, store, and release patient information. This tool is accessible to health professionals in Québec; hence it is an important element of integrating care across professional boundaries. It is not yet clear to what extent the various goals of these reforms have been achieved. Since 2001, no formal evaluations have been carried out by the MSSS.

3 FACTORS THAT INFLUENCED THE DEVELOPMENT OF PHC TEAM-BASED CARE POLICIES

We analyzed 15 ministerial and regional policy documents (Appendix 1) published over the last two decades (2000-2020) and found that several factors influenced the creation of GMFs as the main model of integrated team-based care in the early 2000s. Socio-political pressure due to overcrowded emergency rooms, long waiting lists, and timely access to primary care services drove public demand for health care reforms (Bourque and Quesnel-Vallée 2014). Furthermore, family physicians—who are key actors in the health care system—readily accepted the GMF model because the fee-for-service model of remuneration of physicians facilitated adherence to group medical practices, while the CLSC model required physicians to be salaried state workers (Breton et al. 2011). Other payment modalities like capitation and payment for performance that encouraged interprofessional collaborations were introduced in group medical practices to complement fee-for-service. These included financial incentives for family physicians who registered vulnerable patients from the centralized waiting list, payment for supervising clinical nurses and an annual fee for the registration of patients based on their characteristics (Breton et al. 2015).

4 HOW THE REFORMS WERE IMPLEMENTED

As previously mentioned, the transformation of PHC in Québec consisted of shifts in the composition of GMF teams towards the inclusion of various PHC providers, embedded within wider structural reforms that promoted integrative inter-organizational collaborations among providers located in the same territory. A ministerial policy document entitled *Projet clinique: Cadre de référence pour les réseaux locaux de services de santé et de services sociaux* or The *Clinical Project: Framework for Local Networks of Health Services and Social Services* (MSSS 2004) outlined three main approaches to implementing the 2004 reforms. A community-based approach emphasized organizing team-based services around primary care groups and community services. A *service program approach* required integration of services for specific vulnerable populations, ensuring a comprehensive continuum of care from primary, secondary, and tertiary levels of the health care system. A *population approach* emphasized organizing team-based services according to a geographical area. This same policy document explicitly stated that health and social services centres were required

to lead the creation of LHNs by establishing functional partnerships with all relevant organizations involved in the continuum of care for vulnerable populations of their areas of jurisdiction. Following the 2015 reforms, integrated health and social services centres were required to implement Territorial Health Networks. However, no policy document explicitly outlined the approaches to establish these networks.

Other policy initiatives modified the configuration of PHC team-based care in Québec. For instance, nurse practitioners were introduced into GMFs in 2010, and social workers in 2016. The extended scope of professional competencies of GMF providers enhanced multidisciplinary collaborations within the team. Over the last two decades, multiple health policy initiatives have driven the evolution of the PHC model by progressively enhancing multidisciplinary team-based practices between family physicians, nurse practitioners, social workers, pharmacists, and other primary health care providers in the GMF setting.

5 EVALUATION

Several studies have looked at the impact of GMFs on various health care indicators; their findings are mixed. On examining the number of emergency department visits of diabetic patients before and after the introduction of GMFs in 2002, Carter et al. (2016) demonstrated minimal added benefits to access and the quality of primary care services. In their implementation analysis of GMFs, Beaulieu et al. (2006) highlighted challenges such as lack of interprofessional role clarity between physicians and nurses and difficulties in developing joint clinical tools for chronic diseases. Fox et al. (2019) reported gaps in three main aspects of inter-professional communication in GMFs—coordinating sequential efforts between professionals, assisting in the sense-making of other professionals and working to understand together. Strumpf et al. (2017) demonstrated significant reductions in health care costs and the utilization of health care services of patients enrolled in GMFs compared to patients not enrolled in group medical practices. Another evaluation study revealed improved patient experiences in terms of continuity of care but not accessibility of care with the introduction of GMFs (Tourigny et al. 2010). As the composition and operations of GMFs have also changed over time, it is important to constantly monitor how these changes have impacted the quality and experiences of services.

At a systems level, GMFs operate within broader LHNs. One survey of 297 PHC practices operating within 23 LHNs reported improved inter-organizational collaborations among PHC practices (Breton et al. 2013). Other studies point out the paucity of evaluation studies of the operations and practices of local health networks in Québec (Bourque and Quesnel-Vallée 2014). Nonetheless, ministerial policy documents offer insights on strategies that were put in place to monitor or evaluate LHN practices. *The Clinical Project: Framework for Local Networks of Health Services and Social Services* (MSSS 2004) explicitly described two levels of evaluating LHNs. The MSSS was responsible for evaluating the degree of implementation of LHNs, and continuous monitoring of access to PHC services.

Regional health authorities and health and social services centres were responsible for evaluating the practices of their respective LHNs as a complementary measure to ministerial evaluations.

6 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1: SWOT analysis of policies shaping PHC teams

Strengths	Weaknesses
• Policy initiatives increased the scope of practice of nurses and nurse practitioners. These were aimed at facilitating multidisciplinary team-based practices. • Policy initiatives formalized and provided support for various types of providers in the GMF setting. • LHNs enhanced inter-organizational partnerships between public, private and community organizations involved in the continuum of care for patients.	• The fee-for-service model of funding for family physicians in GMFs was a potential impediment for team-based practices. • Lack of policy direction on how to establish territorial health networks may hinder effective collaborative practices.
Opportunities	**Threats**
• Realizing effective multidisciplinary team-based care between various PHC providers in the GMF setting may improve access and continuity of services to vulnerable populations. • Transferring social workers from the HSSC to GMF may improve collaborations between both organizations. • Leveraging technologies like electronic medical records and Québec health records may improve interprofessional information exchanges.	• Limited evaluation of LHNs may hinder improvement initiatives. • Mixed findings concerning the real impact of GMFs may hinder efforts to refine the model. • The roles and competencies of nurses, nurse practitioners, social workers, and other providers in privately owned GMFs are not always clear. There is a real risk for mis-utilization or underutilization of these providers.

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8 APPENDIX 1: Policy Documents Examined

Title: Cadre de référence de l'approche de partenariat entre les usagers, leurs proches et les acteurs en santé et en services sociaux
URL: https://publications.msss.gouv.qc.ca/msss/document-002061/
Description: Strategic direction document that makes recommendations to increase patient engagement not only at clinical but also administrative decision-making levels. Further description of recommendations for the planning, organization and governance of LHNs.

Title: Cadre de gestion des groupes de médecine de famille universitaires
URL: https://publications.msss.gouv.qc.ca/msss/document-001771/
Description: Management document that outlines the mission of University Family Medicine Groups (GMF-U). These groups have a dual mission of delivering services and training the next generation of health care providers. This policy document outlines the specific requirements of creating a GMF-U that meets this dual objective.

Title: Pratique clinique de l'infirmière praticienne spécialisée en soins de première ligne: Lignes directrices
URL: http://www.cmq.org/publications-pdf/p-1-2019-07-23-fr-lignes-dir-ips-premiere-ligne.pdf
Description: This policy document outlines the specific scope of practice for Primary Care Nurse Practitioners in Québec. It also outlines the duties and responsibilities of this emergent nursing role.

Title: Un Québec pour tous les âges: Le Plan d'action 2018-2023
URL: https://publications.msss.gouv.qc.ca/msss/document-002204/
Description: Strategic direction document that outlines the challenges that primarily effect the population >65 years old. This document includes recommendations concerning seniors living with complex health and social needs.

Title: PLAN STRATÉGIQUE du ministère de la Santé et des Services sociaux du Québec 2015-2020. Mise à jour 2017
URL: https://publications.msss.gouv.qc.ca/msss/document-001550/
Description: This strategic direction document focuses on the integration of health and social services in Québec, with primary health care teams being an integral part of this plan. Broad in scope, it outlines the vision for the future of health care in Québec.

Title: Programme de financement et de soutien professionnel pour les groupes de médecine de famille
URL: https://publications.msss.gouv.qc.ca/msss/fichiers/2017/17-920-09W.pdf

Description: This document outlines the funding structure of GMFs. Funding is dependent on yearly reviews. GMFs must comply with certain policies such as registering a minimum number of patients to be eligible for public funding.

Title: Vers une meilleure intégration des services pour les jeunes en difficulté et leur famille. Orientations ministérielles relatives au programme-services destiné aux jeunes en difficulté 2017-2022
URL: https://publications.msss.gouv.qc.ca/msss/document-001955/
Description: Strategic direction document that outlines the approaches and strategies used to support the Youth Living with Difficulties program. Primary health care teams are included as an essential component of care for this population that has complex needs.

Title: Cadre de référence Les ressources intermédiaires et les ressources de type familial. Direction générale des services sociaux
URL: https://msss.gouv.qc.ca/professionnels/ressources/ri-rtf/cadre-de-reference-ri-rtf/
Description: Strategic policy direction for resources that provide support for people living in the community with complex conditions. This document supports the integration of health and social services.

Title: Accès priorisé aux services spécialisés. Cadre de référence régional.
URL: https://santemontreal.qc.ca/professionnels/drsp/publications/publication-description/publication/acces-priorise-aux-services-specialises-cadre-de-reference-regional/
Description: Strategic direction written by a regional health authority to make recommendations to improve the linkage between primary care and specialized services.

Title: (Loi 10 de 2015) loi modifiant l'organisation et la gouvernance du réseau de la santé et des services sociaux notamment par l'abolition des agences régionales—mise à jour le 12 juin 2018
URL: http://legisquebec.gouv.qc.ca/fr/ShowDoc/cs/O-7.2/
Description: Legislation merges all health and social care agencies. Integrated Health and Social Services Centres (IHSSC) form partnerships with primary health care teams at a local level. This document outlines roles and responsibilities to support integration of the health care system and support of people living with chronic conditions.

Title: Le cadre de référence sur la pratique santé mentale adulte (SMA) en première ligne orientée vers le rétablissement
URL: http://extranet.santemonteregie.qc.ca/depot/document/3825/cadre_ref_SMA1religne_VF.pdf
Description: Strategic direction and evaluation of the adult mental health program in the territory governed by the Montérégie IHSSC (regional health authority). This policy

makes recommendations to support inter-organizational collaborations. Regional/local policies are adaptations of the national guidelines.

Title: Cadre de référence Programme de soutien à la famille pour les personnes ayant une déficience
URL: https://www.ciusssmcq.ca/telechargement/197/cadre-de-reference-sur-le-programme-de-soutien-a-la-famille-pour-les-personnes-a/
Description: Management document making recommendations on how to best support families of people living with a disability. Funding decisions are based on the patient being attached to a team. This incentivizes families to participate in team-based care.

Title: Cadre de référence pour la prévention et la gestion des maladies chroniques physiques en première ligne
URL: https://publications.msss.gouv.qc.ca/msss/document-000455/
Description: Strategic direction policy document for the physical chronic disease program. This document emphasizes the importance of team-based care in preventative strategies and management of chronic diseases.

Title: Relever le défi de la maladie d'Alzheimer et des maladies apparentées. Une vision centrée sur la personne, l'humanisme et l'excellence. Rapport du comité d'experts en vue de l'élaboration d'un plan d'action pour la maladie d'Alzheimer
URL: https://publications.msss.gouv.qc.ca/msss/document-000869/?&date=ASC
Description: Strategic direction policy document that is endorsed by the MSSS as the basis of the Alzheimer's program. This program is currently implemented in 94 LHNs of Québec. It emphasizes the importance of partnerships to address the complex needs of this population.

Title: Projet clinique. Cadre de référence pour les réseaux locaux de services de santé et de services sociaux.
URL: https://eweb.uqac.ca/bibliotheque/archives/18348219.pdf
Description: This document outlines the mergers of acute care, long term care and community services under a single governance structure. The function of LHNs is described as creating partnerships between public, community and private resources.