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RESEARCH REPORT ON THE QUEBEC STUDY CARRIED OUT UNDER THE PAN-CANADIAN PROJECT

CONTINUOUS ENHANCEMENT OF QUALITY MEASUREMENT IN PRIMARY MENTAL HEALTH CARE: CLOSING THE IMPLEMENTATION LOOP (CEQM)

INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC

Québec

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DIRECTION DES SYSTÈMES DE SOINS ET SERVICES

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FOREWORD

The Pan-Canadian “Continuous Enhancement of Quality Measurement in Primary Mental Health Care: Closing the Implementation Loop” project aims at concrete contributions to improve the quality of primary mental health care. It is a major project conducted from April 2004 to September 2006 and funded by Health Canada's Primary Health Care Transition Fund (pan-Canadian envelope).

The numerous partners are evidence of the interest generated by the study. The project’s partners are the British Columbia Ministry of Health, Simon Fraser University, the University of British Columbia, McMaster University, the University of Western Ontario, the University of Toronto, the University of Calgary, the University of Saskatchewan, the Canadian Institute for Health Information (CIHI), the Centre for Addiction and Mental Health (CAMH), the Canadian Mental Health Association, the Institut national de santé publique du Québec (INSPQ), and the Groupe de recherche sur l’inclusion sociale, l’organisation des services et l’évaluation en santé mentale (GRIOSE-SM) in the Quebec region. The principal investigators are Paul Waraich (lead), Wayne Jones and Martha Donnelly (British Colombia); Don Addington (Alberta); John Conway (Saskatchewan); David Haslam and Elizabeth Lin (Ontario); and Denise Aubé (Quebec). An advisory committee comprising researchers, clinicians, planners, and user representatives from across Canada was regularly consulted to shed light on difficult issues and to pretest the various instruments developed during the project. Moreover, many professionals took part in different project stages or worked on developing complementary components. All of these people played an important role in carrying out the project, Paul Waraich (principal investigator) and Radha Puri (Program Manager) being undeniably the project’s main pillars.

A complementary component of the project aimed at developing specific activities at each participating site (British Columbia, Alberta, Saskatchewan, Ontario, and Quebec) to publicize it and generate awareness among stakeholders and mobilize them about the need to improve the quality of primary mental health care and services. As a result, the activities and a portion of the budget were decentralized. The Quebec research leads for that specific component were Denise Aubé (INSPQ and GRIOSE-SM), Monique Carrière (Université Laval and GRIOSE-SM) and Léo-Roch Poirier (INSPQ) as researchers, and Mélanie Saint-Onge as research assistant (INSPQ). Alain Lesage served as a consultant. This research report summarizes the activities carried out in Quebec.

The opinions expressed in this publication are those of the authors/researchers and do not necessarily reflect the official views of Health Canada, or other participating institutions.

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LIST OF ABBREVIATIONS

CSSS	Centre de santé et de services sociaux (Health and Social Services Center)
FMG	Family Medicine Group
MSSS	Ministère de la Santé et des Services sociaux (Department of Health and Social Services)
FMU	Family Medicine Unit

INTRODUCTION

This research report describes the contributions of the Quebec team to the project entitled "Continuous Enhancement of Quality Measurement in Primary Mental Health Care : Closing the Implementation Loop". The main aim of this project is to support efforts at improving the quality of primary mental health care. The identification of a small set of quality measures achieving consensus was the mean retained to habilitate stakeholders to better document their practices on crucial aspects for the quality of health care services. The intervention practices targeted were directly clinical and organizational.

The project's contributions can be broken down into two components: activities to support the pan-Canadian project; and, in Quebec – more specifically in the provincial capital region-the research project endeavored to generate awareness among stakeholders about the need to improve the quality of primary mental health care and services.

The first two sections of the report begin with a brief overview of the pan-Canadian project, including the process in three steps, with information on Quebec participation. More detailed information can be found on the project website: http://www.ceqm-acmq.com. The third and last section, making up the major part of this report, deals with the study carried out in Quebec.

Since this project focuses on quality, quality improvement, and quality measurement, these concepts were defined very early on in the project (Appendix 1). The definition of the concept of **quality** used in this project is that of the Institute of Medicine in 1992 (1). This definition states that quality is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". This definition combines individual and community concerns and is consistent with the current trend towards evidence-based data. A 2003 report published by the Conseil médical du Quebec, "L'imputabilité médicale et la gouvernance clinique") (2) expanded on the quality concept by drawing on another Institute of Medicine publication from 2001. It uses a number of attributes to define quality. This involves fair and prompt access to modern, reliable treatment based on evidence or scientific proof that is appropriate to needs and delivered in a timely manner by qualified professionals. A service organization that promotes quality is therefore based on best practices. This service organization aims at efficiency, that is, a sound cost-benefit ratio, labor productivity, and appropriate use of resources. It also targets patient health outcomes that translate into a decrease in risk factors; a reduction in disease incidence, complications, and disabilities; enhanced quality of life, and fewer premature deaths. The presence of quality also involves a positive experience for the patient and caregiver with the care team, particularly with respect to interpersonal relationships; aspects such as waiting, access, and continuity; exchange of information; the importance given of user choice and involvement; and characteristics found in the physical care environment (3).

According to the World Health Organization (2003), **quality improvement** is a process of ongoing efforts geared to improve performance, which involves identifying problems, trying solutions, and following up solutions on a continuing basis (4). All of the measures sought aimed at intelligently targeting improvement efforts while equipping stakeholders to document their practices regularly. Therefore, it should be specified that, for the purposes of this project, achieving the targeted improvement is not based on establishing standards or targets, nor does it seek to assign blame. It typically involves self-comparison over time.

The definition selected to describe a **quality measure** comes from the Canadian Council on Health Services Accreditation: « a measurement tool, screen or flag that is used as a guide to monitor, evaluate and improve the quality of client care, clinical support services and organizational functions that affect outcomes » (5). Indeed, the quality measures sought are standardized measures adapted to mental-health services delivered in a primary health care setting and used to facilitate health improvement.

1. DESCRIPTION OF THE PAN-CANADIAN PROJECT

The project aims at improving the quality of primary mental health care. Indeed, while 25% of primary care visits concern mental health issues (6, 7) and more than 80% of people who visit a physician for a mental health problem do so in primary care (8), there are currently no mechanisms for measuring the quality of services delivered there. Yet significant discrepancies between the services currently provided and knowledge about effective care have been documented. Given this situation, the project's main is to identify a small set of measures that can be used at the practice level and to support quality improvement in primary mental health care services. The strategy involved is based on achieving pan-Canadian consensus between the main groups of stakeholders concerned with improving primary mental health care and services: service users, clinicians, managers, planners, and researchers. Although five provinces–British Columbia, Alberta, Saskatchewan, Ontario, and Quebec–played a greater role in the project, all regions of Canada and the territories were represented in the third and last survey on the final evaluation of the measures proposed at the end of the process. Throughout the course of the project, all decisions related to its conduct were made by the National Steering Committee, comprising the researchers heading up the participating sites and a Health Canada representative.

Other work based on literature reviews dealt with complementary aspects of the project. As a result, a document was produced describing the conditions required to ensure optimal specification of a quality measure in order to improve care and services[1]. Moreover, a tool was developed to assist practice settings in assessing the conditions in place to facilitate the implementation and use of quality measurement in their settings[2]. The discussion related to the Quebec research project takes into account the results of these literature reviews. These documents can be consulted on the project's Web site at http://www.ceqm-acmq.com.

The final component of the project aims at developing activities in each of the participating sites to publicize the project and generate awareness among stakeholders about the need to document primary care practices related to mental health care and services in order to improve practice. These activities were intended to promote appropriation and use of the pan-Canadian project results at each of the sites. The Quebec research project was developed and carried out under that component.

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[1] Indicator Specification Template" (Data Sub-Project).

[2] The Readiness the Implement Quality Measurement Checklist: (Research Sub-Project).

2. CONDUCT OF THE PAN-CANADIAN PROJECT

This section describes the main stages in the pan-Canadian project to determine the consensus quality measures between the various groups of stakeholders and between the different regions of Canada, while specifying the participation of Quebec's stakeholders throughout the process. The project consisted of three successive stages with consultation through written surveys.

2.1. STAGE ONE: SELECTING AREAS OF INTEREST

The purpose of the stage was to determine project focus by narrowing the 81 aspects of health care identified at the outset of the project (Appendix 2) down to a subset of priority areas (or domains) that were deemed crucial in improving the quality of primary mental health care and services by service users, clinicians, and managers or planners across the country. Twenty-two were selected as priority domains, including 9 system-wide domains pertaining to care and services (e.g., accessibility, continuity, equity), and 13 special areas of focus. (e.g., clinical settings, interventions, specific health conditions, etc.) (appendix 3). After the preliminary survey results came in, focus groups were formed comprising stakeholders from each participating province to discuss areas of convergence and divergence observed across the country before the representatives decided on the final ranking of domains.

2.2. STAGE TWO: DETERMINING BEST HEALTH CARE PRACTICES AND MEASURES

Stage two comprised two components. The first consisted in reviewing the best practices and quality measurements reported on in scientific literature for each of the priority domains. The second was paper survey of experts that made it possible to complete the exercise by adding practices and measures deemed best or useful, but not reported on in scientific literature. Of the 41 experts taking part in this consultation, 22% were users or user representatives, 27% clinicians, 12% managers or planners, and 39% researchers. This stage identified nearly 3000 best practices or quality measures and described their scientific robustness.

2.3. STAGE THREE: SELECTION OF QUALITY MEASURES BASED ON CONSENSUS

The third and last stage involved the final selection of a small set of quality measures covering all priority domains arrived at by consensus between groups of stakeholders and Canada's regions and territories. Given the overlap between the general domains of "efficacy" and "relevance with all other domains," these domains were dropped leaving 20 of the 22 initial domains for consideration in this final stage. The survey comprised 160 of 3000 inventoried practices and measures that were selected with an iterative process using the following criteria set by the National Steering Committee:

1. Coverage of 20 priority domains, giving precedence to measures and practices with high scientific robustness.
2. Integration of the measures currently collected on the pan-Canadian level with these measures.
3. Balance between measure relevance and actionability within the context of primary health care.

The third survey was carried out in two phases: the first sought initial responses to the questionnaire; the second provided respondents with the preliminary analysis of results, both provincially and nationally, including participant arguments supporting their choices. This information enabled them to confirm or adjust their responses (modified Delphi method). Information related to the 160 measures selected is available on the Web site. The results submitted for analysis automatically included the responses from the first questionnaire in cases when the second phase was not carried out. Nationally, 212 people completed the survey, the representation by province and territory being adjusted with their respective demographic weights. Quebec accounts for 21% of the total responses received. The appendix 4 describes the Quebec participation for each stage of the pan-Canadian project.

In addition to activities related to the pan-Canadian process, two information meetings were also held in March 2005 in Quebec and Montreal to publicize the project. These two activities brought together about 30 people from the ministère de la Santé et des Services sociaux, five regional health authorities, one CSSS, four professional orders (physicians, occupational therapists, psychologists, social workers), academia from two different universities and three provincial non profit groups.

Within Quebec, the pan-Canadian project involved a variety of stakeholders concerned about improving the quality of primary mental health care and services. It was possible to achieve the desired representation of the four stakeholder groups targeted under the project in every stage. A total of around 90 people were solicited to take part in a variety of ways in the many activities described above.

3. QUEBEC RESEARCH PROJECT

The Quebec component aims at increasing awareness of the main stakeholders in the Quebec area about the concept of quality and mobilizing them so as to promote interaction between users, managers and clinicians. The general objectives are:

- Stimulate the development of a quality culture in primary mental health care and services.
- Make more people aware about the issue of continuous quality improvement and its measurement in providing primary mental health care and services and to publicize the pan-Canadian project.
- Create conditions that could make primary health care settings more receptive to the results of the pan-Canadian process.

The section begins with a summary of the context of change in Quebec, the reasons for selecting the Quebec area, and a strategy for structuring the project. This is followed by a description of the project and its main results.

3.1. CONTEXT OF CHANGE IN QUEBEC

Like many Canadian provinces and industrialized countries, Quebec is concerned with strengthening primary mental health care. In December 2003, this concern translated into a major restructuring policy. The *Act Respecting Local Health and Social Services Network Development Agencies* has given the 18 regional authorities the responsibility for implementing a new type of service organization within each region in the form of local service networks. In June 2004, 95 CSSSs—created through the merger of local community service centers, extended care centers, and, in most cases, a general hospital—were set up and serve as the foundation in forming local services networks (9). The main primary care stakeholders concerned, in addition to the CSSSs, are community organizations and medical services, which can be structured in different ways: family medicine groups (FMGs), family medicine units (FMUs), and private practices. The users of services and their families are also stakeholders in these service networks. These changes are designed, among other things, to bring services closer to the general public and to ensure access, continuity, and the quality of services to the individuals residing in the local territory (MSSS, 2005) (9). Indeed, the CSSSs view the quality of services as a prime concern. Moreover, the stakeholders offering health and social services to the population of a local territory are encouraged to collectively share responsibility for these people.

In order to achieve these objectives, each CSSS must first work with the partners of their local services network to define a clinical and organizational project centered on interdisciplinarity of stakeholders and complementarity of services (9). People with mental health problems, their families, and significant others figure among the clinical project's main targets. While these changes were being implemented, the ministère de la Santé et des Services sociaux launched its mental health action plan ("La force des liens") in June 2005.

This document emphasizes greater access to primary mental health services and greater collaboration between professionals involved in mental health, in both primary and secondary care. In part, the changes were designed to promote and increase creation of different models of shared mental health care.

The pan-Canadian project unfolded in this timely context. Indeed, the changes underway are accompanied by renewed interest on the part of primary care stakeholders for quality in primary mental health care and services.

3.2. SELECTION OF THE QUEBEC REGION

The importance given to organizing primary mental health care and services varies considerably among Quebec's regions. The decision to select Quebec area as the focal point for efforts related to the Quebec component of the project was based on three reasons. First of all, the region has demonstrated a long-standing interest in organizing mental health care and services and involvement in developing primary mental health services. Nearly 10 years ago in 1997, the care of a significant number of users of ambulatory psychiatric services was transferred to local community service centers. This was over an above the deinstitutionalization of psychiatric hospital patients that took place in past decades. Furthermore, in the first few years of the current decade, a new planning cycle significantly mobilized all of the mental health stakeholders in the service networks.[3] As a result, mental health care and services have remained a major concern in the region. Secondly, the region has a relatively large population (667,876 inhabitants[4]) and offers varied characteristics, such as central urban areas, where the underprivileged are concentrated, and semi-urban sub-regions. These attributes gave an enhanced scope to the results.

Lastly, individual knowledge of most of the existing stakeholders facilitated completion of the project within a tight time frame.

3.3. SELECTED STRATEGY

The research team deemed it important to involve stakeholders with clinical and administrative legitimacy in planning the Quebec regional project. This approach yielded a better understanding of the current situation regarding the use and development of quality measures for primary mental health care and services. Moreover, it makes it easier to take into account the current political and organizational context, in light of the changes underway. The strategy was to have the steering committee, comprised of representatives of the main stakeholders involved in delivering primary care and services within the region, develop the Quebec regional project. In addition to the research team, the committee included a user, a manager within the regional authority, three managers from urban CSSSs, two general practitioners (one from a CSSS; the other in private practice), and the director of a regional community organization. The committee members helped recruit participants for the project's Quebec regional component.

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[3] « Report on mental health services » produced by «Le Comité régional de soutien à la transformation et à la consolidation des services de santé mentale» (June 2002).

[4] Institut de la statistique du Québec (2005).

Moreover, their familiarity with the pan-Canadian project smoothed operations and they continue to be valuable allies in promoting acceptance of the results and for reflecting on longer-term strategies for their use.

4. QUEBEC RESEARCH PROJECT DESCRIPTION AND METHODOLOGY

The steering committee set the following objectives:

- Get a clearer idea of the current position of the various stakeholders involved in delivering primary care and services on the concept of quality.
- Document their current practices in this regard.
- Foster a dialogue between participants with respect to the results achieved.
- Create, on the provincial level, conditions favorable to the medium and long-term implementation and use of quality measures.

The strategy was to carry out an exploratory study in two phases using a qualitative constructivist approach; the first phase served as a foundation for developing the second. To begin with, six focus groups (sessions lasting an average of two hours) were conducted with users, managers, and caregivers from the main organizations responsible for primary mental health services in the region: community organizations[5], urban CSSSs, semi urban CSSSs, FMUs, FMGs, and private practices. The concept of quality was first explored based on the participants' position on quality within their practices, specifying their main concerns, their strategies for improving practices, and their mechanisms for ensuring quality. Clinical vignettes were also used to document current practices with respect to the quality of care and services delivered to users. These vignettes dealt with situations requiring follow-up over the short, medium, and long term (appendix 5). The principal investigator facilitated the groups; a research professional took notes.

In the next stage, all of the participants as well as representatives of three professional orders in Quebec (nursing, social work, and occupational therapy) met in a daylong forum to comment on the results and to review current practices. The forum program included two workshops mixing users as well as actors from each of the practice settings participating in the process. An initial workshop provided an opportunity to discuss the observed convergences, possible synergies, and the role of stakeholders and existing structures in developing a quality culture. A second workshop dealt with the means and tools for promoting a quality culture. At the end of the day, three health network analysts from the Quebec area commented on the day’s content and discussion. Finally, an outside analyst, a retired journalist highly familiar with the health system, agreed to attend our daylong forum with a critical, external and social perspective. He closed the forum by presenting his reflections and questions about the issues raised during the day. The main comments are integrated in our discussion.

In the first stage, participant comments were recorded and verbatim transcripts produced. Syntheses of the themes touched on were first drafted by the principal investigator and the

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[5] The participants from community organizations came from three organizations working in the area of crisis intervention. The organizations were selected because services were provided by professionals, often as a complement to the public services network. The research team made this decision based on the increased importance given to the clinical aspects of interventions within the Pan-Canadian project.

research professional before they were finalized and then validated by two members of each of the focus groups. These members had to confirm that these reflected the majority of the comments during the sessions and made any corrections, if appropriate. Afterwards, the contents were analyzed to identify the main themes associated with quality and to describe current practices. The information related to the clinical vignettes was dealt with globally, because it confirmed and specified the targets deemed important, but did not discriminate between medium- and long-term follow-up. The analysis brought out convergences and divergences as well as distinctive features of the various settings. Since it was deemed important to keep the lapse of time between the focus groups and the forum relatively short (two months), it wasn't possible to use the verbatim transcripts for content analysis. In the second stage, syntheses of the discussions between participants and comments by the external analyst were used to produce an overview synthesis.

During the first stage, it was possible to reimburse participating professionals for their time, when required. Users received an allowance for their expenses and compensation for their participation during both phases of the Quebec project. The Quebec project was approved by the research and ethics committee of the Centre de santé et des services sociaux de la Vieille-Capitale. Participants in the group discussions received consent forms before the sessions were held, which they signed and then handed in at the gatherings. The discussions were recorded with their consent. All participants in the forum workshops also received and signed consent forms. Activities were carried out on a volunteer basis, allowing participants to withdraw at any time without bias or the need to justify their decision.

5. RESULTS

5.1. FIRST STAGE OF THE QUEBEC RESEARCH PROJECT

A total of 39 people took part in the group discussions. Table 3 provides information about group composition.

Table 1: Group composition

Group Name	Number of Participants N = 39	Group Composition
Users	5	4 users of services and 1 member of the general public
Community Organizations (crisis intervention)	8	2 policymakers and 6 caregivers
Urban CSSSs	8	3 policymakers and 5 caregivers
Semi urban CSSSs	8	2 policymakers and 6 caregivers, including 1 physician
FMUs	5	2 physician and 1 psychologist 1 nurse and 1 social worker
FMGs and private practices	5	4 physicians and 1 nurse

In presenting the results, the expression "practice settings" refers to: community settings, urban CSSSs, semi urban CSSSs, FMUs, FMGs, and private practices.

The presentation of results begins with general remarks about the concept of quality broken down into the following themes: common and specific concerns about service organization, quality practices, problems arising from quality measurement, and the means currently used to document or structure practice. This is followed by the results of the discussions about the clinical vignettes; the themes dealt with are broken down according to the degree of consensus between the six groups.

As a preface to this, however, a certain number of observations during the discussions deserve mention. While each practice setting is different, they all are interrelated. The medical settings (FMUs, FMGs, and private practices) and the community settings show the most tenuous ties. The physicians felt that they were not sufficiently familiar with the resources in community settings, which was confirmed by organization representatives. The physicians perceive community settings as being quite different from one another and often have the impression that the medical approach is negatively perceived. Moreover, FMG staff has observed that access to services varies from one CSSS to the next and the physicians in private practice have observed that the CSSSs enjoy special relationships with hospitals that they themselves do not have regarding access to information about users. Generally, the participants from FMGs and in private practice appear to be the most isolated.

5.1.1. Concerns about Quality

Common concerns related to service organization: The users emphasized that they do not know where to go or whom to see in the services network when the need arises. For their part, the participants from four practice settings mentioned the complexity of navigating through the health care network when many services are required; this applies to both users and the caregivers themselves. The five practice settings all felt that the system is overloaded due to a shortage of human resources. Four of them felt that there is a shortage of medical resources and are worried about the context of "turnstile" consultation context generated by walk-in appointments.

The participants from semi-urban CSSSs and the physicians in FMGs and private practice pointed out their difficulties in having access to specialized resources. They also mentioned that there was inequality in access depending on home territory because the region is divided into two catchment areas with different rules for accessing specialized services.

Specific concerns related to service organization: The community settings involved in crisis intervention deemed it important to develop integrated services networks. They are proud of the services they provide, 24 hours a day every day, and the home intervention services that they have just initiated. They are constantly working to improve linkages between the various community organizations and advocate a double-entry-point system for primary care services: one through the public services network and the other through the community network, given the value represented by the approach centered on community support provided by community settings. They also have observed congestion in the use of services provided by the public network in the case of medium- and long-term follow-up.

The CSSS participants were very concerned about the waiting lists and waiting times, since users can experience significant distress while waiting for care or not have their needs met in a timely fashion. They advocated offering users a variety of options when delivering services (individual or group intervention or the use of complementary resources), while placing a great deal of importance on the functions of liaison and intake, internal team meetings, and more coordination activities with partners. They emphasized the role that the organization must play in developing and maintaining quality and in motivating personnel. Furthermore, they called attention to the importance of staff buying into the organization's values. The representatives of a semi urban CSSS stated that they felt vulnerable when staff left, often to go to urban settings, resulting in disruptions. On the other hand, they pointed out a special degree of closeness between the various resources and caregivers in the territory.

Medical settings expressed concern about the number of caregivers that users must consult when they are referred elsewhere. They placed importance on the presence of functional service corridors based on the importance of the problem and not on the user's home address. They would like to have more direct links with specialized services, even more so when mental health represents a significant portion of their practices. They are concerned about users referred to primary care providers by specialized services, given the subsequent difficulty that users have in gaining access to specialized services in the future. Representatives from the medical settings want to preserve several entry points into the services network and have access to an individual who is thoroughly familiar with community resources. They also stressed the value of the existing networking between a CSSS's mental health team and medical clinics in the territory.

Conditions Associated with Quality Practice: The participants identified a number of conditions deemed important to ensure quality practice:

- Attitudes to avoid diagnostic prejudices and manage the person, not a case.
- Relational quality in order to create a bond with the user, establish a sound helping relationship and, when required, conditions conducive to medium- and long-term follow-up.
- Close relationship and respect among caregivers to avoid unnecessary duplication, working alone, becoming isolated, and not receiving support.
- The development of enhanced partnering between physicians and other professionals to make better collective use of the available resources because the problems are often complex and complementarity exists.
- The flexibility and judgment required when difficult issues must be dealt with, such as choosing between relational continuity and recourse to other caregivers in complementary areas or to specialized resources, or even when a pivotal caregiver must be determined.
- Continuing adjustment because problems change and are often complex.

Four practice settings emphasized that caregivers must be able to recognize their limits and all agreed on the importance of competency, although how to measure it is not very clear. The targeted aspects are:

- Improving diagnostic skills and basic mental health attitudes.
- The ability to intervene with people with multiple problems.
- Improving skills related to problem solving and managing emotions.
- Improving relational qualities, because they determine the user's interest in follow-up.

CSSS participants emphasized the competency requirements for key positions, such as intake, and the need to apply a consequent recruitment process that, in the current operating context, would involve negotiating with union authorities.

Representatives from all the settings gave equal importance to training. The participants from community settings insisted on the development of attitudes; the CSSSs focused on training to use the right tools and guidelines on best practices, since one of the concerns focused on achieving quality standards. FMUs—the training ground for future physicians—viewed training as of capital importance. Clinical guidance is ubiquitous in their setting and they value the helping relationship, relational aspects, and learning through observing role models. Teachers are on the lookout for both individual and collective training needs. These settings use a variety of formal assessment methods to verify the quality of interviews (which must be patient centered), skills for constructive self-criticism, and the self-learning capacities evidenced by future physicians. The assessments are carried out by supervisors on an individual daily basis with residents and in group settings when teachers meet for this purpose.

Problems arising from quality measurement: Participants raised a number of difficulties related to quality measurement. They consider that current instruments have limitations in that they cannot determine if certain final objectives have been achieved (such as recovery or social integration). Satisfaction measures, for their part, do not take into account the results. The participants from community settings brought up that the regular use of quality measures requires time and mentioned the pressure to demonstrate their level of use of facilities in order to receive a portion of their operating grants. CSSS participants stated that they felt pressure to increase their volume of services. Lastly, it was brought up that the use of quality surveys and satisfaction measures do not always translate into feedback to the concern caregivers. Participants wondered if there were not grounds for separating quality of service, which is more organizational in nature, from practice quality, which is more professional in nature. Moreover, users were concerned about interpretation issues arising from unusual cases or different environmental contexts.

The various groups gave precedence to different measures. Many participants, including users, would like to measure the achievement of an objective established at the outset of the intervention. Participants from community settings would like to see recovery verified; those from CSSSs preferred the functionality of users in their various social roles. Moreover, participants deemed satisfaction measures important, despite their limitations, because they provide a means for tapping into user concerns and give users some degree of control over the services delivered. Certain groups also wanted other aspects of practice to be subject to quality measurement: different treatment options (users); power given to users in the offer of services (community settings); effectiveness achieved in serving the greatest number of people in need, thereby limiting waiting lists (CSSSs); user satisfaction in consulting a physician, the pleasure caregivers take in working together and collective mutual aid (FMUs).

The means used to structure or document practice: This applies mainly to CSSSs and community settings, who follow different policies and procedures in structuring their practices. The CSSSs mentioned quality enhancement programs[6] (code of ethics, complaint procedure, practice standards and norms), protocols to clarify the service trajectory, and administrative follow-up of caseloads to adjust resources, if required. For their part, community settings have specific activities to develop the attitudes sought (training sessions) and discuss policy directives (seminar every two years). The mechanisms for exchange between caregivers include: team meetings (CSSSs), case information during shift changes (community settings), use of a pivotal caregiver (CSSSs and community settings), and a communication sheet used by a CSSS and territory physicians. Feedback mechanisms include satisfaction forms and quality surveys for users (community settings) and periodic reassessments (CSSS).

Clinical tools are also used to ensure or demonstrate the quality of care. Representatives from the medical settings indicated that objective scales can be used to establish a diagnosis, systematic management protocols, and notes to be entered in the patient's chart. CSSSs use scales to establish case priority.

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[6] NB: The *Health and Social Services Act* requires institutions to implement a code of ethics and procedures for handling complaints.

In short, quality is a topic of interest for all settings, representing different practice challenges. The participants emphasized the quality of interactions (attitudes, relational quality, complicity, flexibility, and judgment), the importance of knowing how to address clinical problems (competence and training), and considerations related to service organization (existing, accessible, and complementary services; varied offer of services, functional service corridors, and organizational support). While some concerns are shared, each setting is different and identified different aspects that they deem more important in terms of quality.

The participants pointed out again that quality measurement had limits and remained a major challenge. Moreover, its measurement does not imply that the results will be used to improve practice. The instruments raised by the participants were varied, responding to different requirements: rendering of accounts, practice systematization, and the need for common instruments when providing care jointly.

5.1.2. Important Themes Emerging from Practice

The discussions about clinical vignettes (presented in appendix 5) brought out a number of actions deemed important in assuring the quality of care and services. The actions mentioned by at least four of the six groups are given along with their degree of consensus.

All groups, including users, unanimously agreed on four actions: guidance and reassurance of users; various forms of assessment; establishing continuity of care and des services; and intake quality.

- From the standpoint of participants, user guidance and reassurance translate into establishing an action plan, explicitly describing short- and medium-term follow-up, a safety net, short- and medium-term solutions to the user's problems, and information about the actions to take if the problems occur. This theme came up very frequently in five of the six groups.
- Assessment can take different forms, depending on the case and the practice setting. This theme came up repeatedly except among users and participants from community settings. Assessment can include physical and mental aspects; partial or comprehensive biopsychosocial assessment; patient and family history; knowledge of the environment, parenting skills, interpersonal skills, and level of energy. The issue of assessing the situation's impact on the individual and family circle was also brought up. The participants from semi urban CSSSs and medical settings specifically mentioned mental health assessment: assessment of the five axes (DSM-IV); stress and distress factors, family mental health history, and risk of suicide or homicide.
- The importance given to continuity varied according to group and the clinical cases presented. The various elements deemed useful in establishing continuity of care and services are: ensuring that users have used the recommended services; instituting medium and long-term follow-up, if necessary; ensuring continuity of treatment and interventions; ensuring relational continuity, sometimes through a pivotal caregiver; and creating a relationship that is conducive to consulting if need be. At the same time, the concerns about not creating dependency and of respecting the user's choice when implementing follow-up were brought up.

- While all groups mentioned the importance of intake but not very frequently, the statements indicated its fundamental nature and that it was deemed a priority.

Six themes were raised by the users and by the participants from four practice settings, namely, communication of information, user empowerment and respecting user choices, speed of access to services, interest in establishing medical follow-up, linkages between caregivers and the sources involved, and, lastly, the quality of listening.

- Different means provide for the communication of information: conveying previous records, log sheet, communication sheet, and verbal exchanges between caregivers. A number of participants related difficulties resulting from a lack of communication, particularly lost time and starting over. The participants from medical settings brought up the importance of effective communication of information more often than the others.
- User empowerment and respecting user choices figured as important values, even if they resulted in destabilization or a relapse. Participants are aware of the risk involved in letting the user decide, just as there are risks in deciding in the user's stead (reinforcing the feeling of powerlessness).
- The importance of rapid access was frequently raised by the users, participants from semi urban CSSSs, and community settings. The latter consider that they stand out from other care providers for their ease of access. The participants defined rapid access in different ways: "reasonable delay," "as soon as possible," "24 to 48 hours," and "fairly rapidly."
- The users and participants from four settings raised the interest of medical aftercare in response to the clinical vignettes requiring medium- to long-term follow-up.
- The users frequently brought up the importance of links between organizations and caregivers, in sharp contrast to the other groups, although representatives of the community settings raised the issue a few times in response to the specific context of long-term aftercare (3rd clinical vignette).
- The theme of listening came up rather infrequently, with the users bringing it up most often. These elements were raised: that caregivers should take the time required, that they should be prepared and available, that they should use active listening, that they should ensure that the user has understood, and, conversely, that the user has been understood.

All five of the practice settings were in agreement on two themes: the importance of triage, orienting users, and, when required, the use of complementary resources and the importance of assessing the social network.

- The importance of triage, orienting users, and, when required, the use of complementary resources was frequently raised by all practice settings. They were aware, however, that doing so ran the risk of losing sight of some users, particularly youths and men. Nevertheless, many advantages were raised: promote the optimal use of all resources; avoid recourse to waiting lists by using the most available resources; find a service appropriate to the individual and quickly prepare the user for some of his or her needs; and build a support network around the individual. Still, participants raised a word of caution about running the risk of deciding for the user.

- Representatives of all the practice settings brought up the social network, but not frequently. Three of them (more frequently community settings) raised the importance of mobilizing the network.

Lastly, two other themes were raised by four practice settings: the quality of information provided to users and the importance of accompanying users in certain situations. Information touches on different aspects depending on the setting: clarification of the caregiver's role and the description of the caregiver's support; description of the anticipated service trajectory and information about the anticipated timeline; and explanation of the issues in not taking the proposed medication. The importance of being frank with the user was stressed. The importance of accompanying users was raised infrequently and then with respect to accompanying the user in making decisions, the steps to be taken, or in recourse to another caregiver.

During the discussions generated by the clinical vignettes, it was evident that the participants did not limit their conception of quality care and services to clinical aspects (assessment). Taking into account the user (information, respecting choices) and the user's network (mobilization), user reassurance, and functional circulation through the system figure among the conditions associated with quality care and services. The quality and relevance of the links established between the different caregivers involved in user follow-up rank among explicit concerns.

5.2. SECOND STAGE OF THE QUEBEC RESEARCH PROJECT

This second stage aimed essentially at giving rise to dialogue between the participants from the different settings about the results. The forum held in May 2005 brought together 45 people. The results came mainly from workshop content. Table 2 provides the origin and status of the participants.

Table 2: Origin and status of participants in May 2005 forum

Group/Setting of Origin	Number of participants N = 45	Status
Users	6	5 users of services and 1 member of the general public
Community organizations	9	3 policymakers and 6 caregivers
Urban CSSSs	11	5 policymakers, 1 psychologist, and 1 physician 2 occupational therapists and 2 caregivers
Semi urban CSSSs	3	1 policymaker, 1 worker, and 1 nurse
FMU	3	1 physician, 1 psychologist, and 1 social worker
FMG and private practices	4	3 physicians and 1 nurse
Professional orders	3	1 psychologist, 1 occupational therapist, and 1 social worker
Université Laval	4	2 researchers and 2 professors
Other	2	1 policymaker and 1 research officer

The results are presented according to the following five groups: the first summarizes participant reactions to focus group outcomes; the second describes the comments leading to more in-depth discussion of certain themes deemed important to promote the quality of care and services; the third deals with proposals to improve quality; the fourth identifies difficulties that must be taken into account as well as the areas of tension and issues raised by participants; the fifth and last section presents the most salient remarks of the outside analyst.

General comments: The participants confirmed that the results faithfully reflected the group discussions. In particular, this confirmation was strongest in the remarks related to concerns about assessing individuals requesting services, networking with physicians, work overload, difficulties in linking, the waiting time issue, and the shortage of resources. Moreover, participants emphasized that the quality of services is contingent on the quality of interventions.

Additional comments on themes deemed important in promoting quality: While a number of themes were stressed, four were emphasized in particular: intake, continuity of care and services, optimal use of competencies, and clinical supervision.

- Intake is considered a critical issue in the request for services. A number of participants stressed the importance of intake resting on the shoulders of a senior caregiver and that the number of years of experience plays a role in the clinical quality of the service.
- The participants considered that the development of ties between caregivers working in the various organizations constitutes an important condition for ensuring continuity of care and services. The participants were of the opinion that collaborative and complementary ties are based on good knowledge of the setting's resources, on the one hand, and on the development of personal ties between caregivers, which will then give rise to ties built on mutual trust, on the other.

- Many participants felt that a better use of competencies would provide for optimal use of the specific skills of network caregivers, thereby improving the quality of care and services. Although shared competencies are desirable and necessary, participants believe that quality would be improved if the competencies specific to the various professions were better acknowledged in primary care. Consequently, defining respective tasks—especially in a multidisciplinary context—appears important. It was suggested that each caregiver systematically examine their capabilities in order to determine if they are best suited to provide care. Opinions, however, are divided. Furthermore, it is not clear how compartmentalization of competencies would work in a network environment. In addition, this approach does not correspond to the community setting, which advocates a more systemic approach, and it also impacts on relational continuity. Lastly, participants indicated that physicians are reluctant to delegate responsibilities and their tendency is to assume follow-up of users.
- Participants emphasized the importance of clinical supervision in developing and maintaining competencies. Examples were cited of pairing veteran and new employees. Moreover, it was pointed out that young residents are vulnerable due to the demanding requirements of the workplace.

Lastly, participants expressed the opinion that certain clientele required specific attention if quality of care and services were to be improved. Problems related to access to services for men and the complexity of managing users with more than one mental health problem were specifically mentioned.

Avenues and solutions to improve quality: The participants raised a certain number of lessons learned that must be consolidated: team meetings, supervision activities, standard tools for contributing to quality (quality clinical notes, priority ranking scale developed with partners, intervention plans). Protocols were also perceived as useful; on the downside, they increase the operational burden and can be a disincentive to initiatives. Using practice guides was also mentioned as being laborious sometimes.

Two ideas to pursue were: to jointly develop scales and communication sheets between CSSS and physicians in territory to develop a professional portfolio giving the strengths and shortcomings as well as means that have been or could be undertaken for improvement (Ordre des ergothérapeutes du Québec). A number of other ideas were also proposed, including:

- Have a psychologist available for intake to improve assessment.
- Ask ourselves questions about clients that haven't been reached to improve the offer of services: for example, those who fail to show up for several appointments, who are on waiting lists, or who don't consult despite being significantly distressed.
- Institute two scheduled annual meetings per sector of activity where the staff in a territory could exchange their experiences and ideas.
- Offer more evidence-based training in practice settings.
- Provide more documentation on effective practices and interventions performed in the region.

- Add a field for "Outcomes" in the statistics already maintained by CSSSs to indicate if the user's objectives have been achieved.

Difficulties and areas of tension: The participants recalled the demands imposed by the current context of change and having their capacity for adjustment continually put to the test, thereby entailing the risks of burnout. They brought up the importance of having a work environment that supports professionals and has a minimum of vital resources; the importance of a work climate conducive to creativity and exchanging information; the importance of recognizing the value of professional judgment and work performed.

Lastly, many areas of tension and questioning emerged during exchanges between participants:

- Divergent concerns regarding quality on the part of managers and caregivers.
- Difficulty reconciling the concern for establishing relational continuity with users and recourse to additional, specialized, or complementary caregivers.
- Using tools initially designed for administrative purposes to measure quality (e.g., priority ranking scale).
- The challenge of integrating recovery into the measurement for assessing the interventions on the user's health.
- The limitations that service trajectories impose on deinstitutionalized clients with multiple and complex problems as well as the challenges inherent in a recovery approach.
- The need to take an interest in user's family and significant others during impact studies, while there is currently no effective instrument for measuring the impact that the interventions have on the family.

Most salient remarks made by the outside analyst: In addition to observations, the outside analyst offered two caveats. First of all, the current process did not include families and significant others of individuals with mental illness, who also would have things to say about the quality of mental health care and services. Secondly, caution should be exercised in interpreting the silence of a group of participants on a particular theme, because it does not mean that the theme is unimportant.

The outside analyst also wanted to remind us that quality cannot be dissociated from a scale of values (which cannot be set aside), that the criteria selected to assess quality must relate to these values, and that nothing unites more than a shared ideal. He is of the opinion that the quality of care and services cannot be separated from a rendering of accounts—that the health care system must provide to society—and that basis of this assessment reflects the values conveyed by our society. While not everything is quantifiable, quality can be assessed, so that qualitative measures also have their place. The analyst used the experience gained through the Healthy Cities and Towns project to illustrate his remarks, reminding participants that indicators can be invented. Lastly, he felt that a quality culture can only be instituted once all the criteria for assessing quality have been identified and assessed.

The participants felt that this second stage confirmed that our results make sense and enabled us to explore some of them in greater detail. Moreover, this stage also demonstrates the concern, vitality, and creativity of the settings in forging ahead in their quest for quality. In addition, the participants reminded us that there are zones of conciliation based on choices and values, which are subject to specific analyses. Lastly, the analyst emphasized the importance of the values underlying the quest for quality and proposed positioning the quest in a more global social context. He aptly pointed out that the lack of input from families and significant others represented a shortcoming in need of remedy.

Most of the participants at the May forum demonstrated their appreciation for the activity: 38 out of the 45 participants (84%) completed their assessment forms and were generally very satisfied. Beyond the presentation of the Quebec project results, two workshops were held. The first one aimed to identify convergences and synergy between primary care settings to better equip themselves in the appreciation and improving of quality. There was also interest for actors' role and structure place in quality culture development. The second workshop was about means fostering quality culture, mainly available tools and exchange settings. Specifically, the participants considered that the themes dealt with during each workshop were relevant (97% and 100%); they felt that they had learned a great deal about the other settings through the workshops (84% and 97%) and they stated that the workshops gave them ideas to act on quality in their particular setting (82% and 92%). Overall, they appreciated the opportunities afforded during the activities to interact with the presenter (92%) and other participants (95%). They also were pleased with the aptness of the analysts' remarks (92%) (appendix 6 and 7).

5.3. STUDY HIGHLIGHTS

The following are highlights from our study.

- The large number of targets relevant to maintaining and improving the quality of primary mental health care and services.
- The singularity of components of the primary care network, expressed in particular targets reflecting the values deemed important and meaningful.
- The identification of conditions related to quality practice that go beyond holding knowledge and that deal with attitudes (relational quality, respect, individuality), aptitudes (flexibility, judgment, continuous capacity to adapt), and seeking out partnership.
- The openness of the settings involved towards collaborative practice deemed necessary in a context of shortages and ever increasingly complex issues.
- The limitation of measures resulting from administrative concerns (clientele volumes, satisfaction) and the absence of measures dealing with the medium- and long-term effects of interventions (recovery, functionality).
- The areas of questioning crossing the quest for quality: the divergent concerns of managers and caregivers, the tension between relational continuity and collaborative practice; the use of instruments initially designed for administrative purposes; and the little regard given to family members and significant others.
- The assessment of interactions raised by the Quebec process aimed at specifying and consolidating the importance given to quality; identifying the positive experiences and

promising options specific to the current practice context; and to broaden the range of options contemplated for better action through sharing.

- The necessary recognition of the values underlying the quest for quality and putting them into perspective within a broader social context.

6. DISCUSSION

The objectives pursued in the Quebec study were to have clearer idea of the position of the various primary caregivers with respect to quality, to document their practices in this regard, to instigate a dialogue between participants about the outcomes, and, more broadly, to create conditions on the medium and long-term conducive to implement and use quality measures, including those identified in the pan-Canadian project.

In our opinion, the use of a credible regional steering committee bringing together the groups of concerned stakeholders, the seeking out of a relevant representation of the main primary care practice settings working in the region, and the use of interactive methods throughout the project resulted in conditions conducive to the dialogue sought out. Moreover, we believe that this is evidenced by the attendance in May 2005 forum and the high level of satisfaction expressed by those taking part. The material collected provided the means for exploring the concept of quality as perceived in practice settings from a number of different viewpoints. It yielded a better understanding of the current stands taken by the settings related to quality as well as a glimpse of the strategies, means, and instruments structuring their practices with regard to quality. This approach focused on practice gives direction to the discussion on quality because it is rooted in the actions carried out, the means used, and the anticipated outcomes.

For the purposes of this discussion, we will strive to juxtapose our process and outcomes with respect to those of the pan-Canadian project.

6.1. THE CONSULTATION PROCESS AND OUTCOMES

In the pan-Canadian process, the targeted groups of stakeholders (user representatives, clinicians, managers and planners) guided the project by selecting the domains for which knowledge about best practices and quality measures would be inventoried. Best practices are those for which contributions to health results, direct or indirect, are confirmed by rigorous studies. Afterwards, knowledge and its scientific robustness made it possible to establish the list of measures for the final survey. The range of domains covered - 20 - provides for diversity, while the small number of measures selected yielded good scientific robustness. The importance given to best practice results however in potential targets being mainly influenced by clinical care, which is studied more systematically.

The Quebec process calls on the same group of stakeholders but roots the quest for knowledge in practice, taking into account the significant diversity of primary care practice settings in Quebec. Consequently, certain entities are more medical (private practices) or psychosocial (crisis-intervention settings) in nature; others are more or less multidisciplinary (FMGs: nurses and physicians; FMUs and CSSSs: physicians, nurses, social workers, psychologists, specialized educators, and so on). On another level, this diversity translates into practice conditions that distinguish community settings, private medical settings, university teaching settings (FMUs), and the eminently public nature of the CSSSs, which are completely different with respect to the size and deployment of their administrative structures. These different practice conditions guided the constitution of the groups.

This diversity colors our results. The concerns related to quality significantly exceed the knowledge gained from evidence-based data. They deal with self-knowledge (attitudes and aptitudes), touch on the organization context (adequate resources, quality of organizational support), and pay particular and renewed attention to partnering and collaborative practices. Some have a systemic aim (greater efficiency for better access); others focus on users and their significant others (independence, empowerment, mobilization). It appears that, when taken one-by-one, these concerns cannot truly take into account the reality because there are many facets that must fit together to achieve quality. The concerns brought up testify to the current context of change, the shift towards network operation, and the limited resources. They do not, however, set aside the instrumental (nature of the incentives) or political (uniqueness of settings) character of quality measurement.

In order to better understand the diversity of the potential targets for improving the quality of care and services, we find useful to place them in a framework that highlights their different natures. The framework proposed in 2000 by Campbell *and al.* was retained (10). It appears especially interesting in this regard because it integrates this diversity. Moreover, it provides a means for situating the aspects covered in the pan-Canadian project, which relate more to medical care in which evidence-based knowledge is concentrated (effective use of care). Campbell uses a disaggregated definition of quality (rather than generic) based on the concepts of access and effectiveness[7] that he breaks down according to structure, processes, and outcomes. The tables below summarize the dimensions of quality of care proposed by Campbell. Table 5 presents them from the individual standpoint, while Table 6 takes the population view.

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[7] *"Quality of care for individuals: whether individuals can access the health structures and processes of care which they need and whether the care received is effective," p. 1614.*

"Quality of care for populations: the ability to access effective care on an efficient and equitable basis for the optimisation of health benefit/well-being for the whole population," p. 1617.

Table 3: Dimensions of the quality of care: individual approach according to Campbell *et al* (2000)

QUALITY	CARE		
	Care System (structure)	**Patient-Centered Care (process)**	**Consequences of Care (outcomes)**
Accessibility	Geographic/physical access Availability: • Organizational access* • 1st contact • Comprehensiveness • Provider continuity	Ability to pay Financial barriers Opportunity costs Having to accommodate competing social roles	Acceptability
Effectiveness		Clinical/technical effectiveness: • Technical aspects of interpersonal care • Effective use of care**: o Application of evidenced-based data (theoretic efficacy) o Use of care that is considered legitimate (widely accepted) Interpersonal care (interaction): • Social and psychological interactions between the patient and caregiver Coordination*** or integration of care	Health status User evaluation: • Satisfaction • Enablement • Assessment of outcome • Health-related quality of life • Processes care (skills of the health professional)

Table adapted from Campbell *et al.* (2000)

* Organizational access: length and availability of appointments, health professional can speak the user's language, access to specialized care depends on the primary care practitioner's decisions.

** Effective care requires alignment of the professional's and the patient's objectives, which correspond to the patient's reasonable expectations and contemporary professional standards of care, reflecting both societal and professional norms.

*** Coordination refers to the effectiveness with which health professionals deal with those of other organizations, or other professionals within the same organization, which impact directly or indirectly upon the health or health-related qualify of life of the patient.

Table 4: Additional quality of care dimensions within a population-based approach, according to Campbell *et al.* (2000)

QUALITY	**CARE**		
	Care System (structure)	**Patient-Centered Care (process)**	**Consequences of Care (outcomes)**
Accessibility	Equity • Horizontal: equally accessible to all • Vertical: greater access for those with more need		
Effectiveness		Efficiency: • Focusing on procedures that produce maximum benefit • Employing techniques in the most technically competent manner • On an equitable basis	Efficacy: • Costs • Equity

Table adapted from Campbell *et al.* (2000)

In that framework, the dimensions take into account the diversity of the concerns expressed by the participants in the Quebec study. Organizational access, relational continuity, interpersonal care, habilitation, and efficiency are a few examples. The framework includes the pan-Canadian outcomes, which tend more towards theoretical efficacy, and those of the Quebec process, which attach importance to interpersonal care and more broadly address the consequences of care. Using the framework provides insight into the complementary results of the two processes.

The results of the Quebec process make it clear that the Quebec stakeholders have varied concerns from the standpoint of quality assessment and those concerns extend significantly beyond reaching clinical efficacy based on evidence-based data.

6.2. QUALITY MEASURES USED

With respect to quality measure, the systematic documentation of data–that the Quebec participants often associate with administrative accountability–results from incentives that are most often external (responding to legislative requirements for CSSSs; access to regional funding for community settings). Moreover, FMUs use systematic clinical assessment procedures (formal and informal), focused inwardly, in relation to their educational vocation. However, the CSSSs identified developing common instruments jointly with targeted partners as a promising option in improving quality, making it possible to structure and standardize collaborative practice, while improving information transfer. Most of the participants saw in this a very positive potential when the leadership and required local investment are present. We can observe that the participants did not address the question of computerizing practice or electronic medical records, which remains in its infancy in Quebec. This may also be related to the diversity of the primary care settings considered, knowing that in some settings the medical practice is absent or not predominant. Lastly, participants felt that the use of measures to describe practice quality represented an investment in administrative resources and caregiver time. The settings, however, stated they were operating in a context of shortages.

So, the actions undertaken with respect to quality measures were different and weakly tied to standardization and systematic data-gathering processes. The following observations came out:

- The presence of incentives when systematic measures are used, often in a context perceived as one of administrative accountability.
- The undeniable positioning of teaching settings in assessing quality.
- The existence of local initiatives to instrument collaborative practices; those initiatives create links and reinforce collaboration.
- The lack of emphasis on computerizing practice.
- The recurrent perception of operating in a context of shortages.

6.3. RECOMMENDED QUALITY MEASURES

The participants expressed a desire to have information about the medium- and long-term outcomes of interventions, giving, as an example, the road to recovery (community settings) or the degree of functionality achieved in the various social roles (CSSSs). Interveners express a marked interest for that kind of results. However, health outcomes are not always clearly associated with care processes, they are contingent upon a wide variety of factors and the time required to achieve them is sometimes quite long. Moreover, some results relate to the natural history of diseases, rather than the logical consequences of processes. According to Campbell, process measures remain the best indicators of quality of care when the objective sought is to influence the behavior of a care system because these processes are under the control of health care professionals and can be more rapidly modified. So, it must also be taken into consideration that medium- and long-term outcomes offer significant limitations in reflecting the quality of care processes. The selected orientation in the pan-Canadian project focus on interventions with short-term efficacy, because the results are easier to evaluate. Yet, those results don’t guarantee medium-and long-term health results.

Adjustments are required to ensure that interveners and manager expectations related to outcome measures are compatible with what can be realistically measured in day-to-day practices. Moreover, some strategies are necessary to establish what links are possible between care processes and medium- and long-term results as well as how they should be documented.

6.4. IMPLEMENTATION OF QUALITY MEASURES

The study's results provide the means for defining the practices and concerns of care settings with respect to improving the quality of primary mental health care and services. Stakeholders and settings alike are concerned with quality and there is a tangible awareness of its importance and of the efforts required when striving for greater quality. At the time of the study, however, there was no indication of a concerted action to structure the development and use of quality measures. The matter is complex, not only because of the diversity of the stakeholders and settings involved, but also because the quest for quality requires specific joint investments as well as a sustained human and physical infrastructure. Under the pan-Canadian project, Kyle *et al*. (11) developed a control list to check for known conditions favorable to implementing quality measures in a specific organization (appendix 8). This list includes elements such as a bias in favor of quality measurement at all levels of an organization; practice conditions modified in response; incentives; a budget earmarked for quality; a staff dedicated to implementation and use of measures; recourse to academic detailing; physician compliance with the selected protocols; the involvement of local leaders; teamwork; computerized practice; a work force trained to support staff; and so on. This, of course, is in addition to a systematic process for selecting quality measures. While the remarks did not specifically address these conditions, they implied rather that much remains to be done in order to achieve them.

Two settings stood out as key players in improving the quality of care and services but for different reasons. Because of their legal obligations, CSSSs focus in on quality as evidenced by the policies and procedures they already have in place. Moreover, their concerns about quality norms and standards are clear. The specific responsibility that CSSSs have in developing local networks puts them in a privileged position to play a key facilitating role among the settings with respect to quality. As for the FMUs, because of their teaching mission, they have already integrated systematic quality assessment processes into their method of operation. Furthermore, they are already at the cutting edge of knowledge and practice modes, which allows them to modify their practice models in response. Consequently, these two practice settings appear to represent the foundations on which to build in the future.

In fact, all of the primary care practice settings involved in this study are concerned with improving primary mental health care and services. The targets for improving practice, however, are varied: some are shared; others are specific to practice settings. The use of a fairly systematic reference framework makes it easier to understand this diversity. The context of shortages and the increasing complexity of problems enhances interest shown in collaborative practices. Locally, certain conditions make it possible to jointly develop instruments that are useful in improving the quality of joint management. Nevertheless, the development, implementation, and routine use of quality measures requires targeted, sustained investments dependent upon political, organizational, and professional will. In the Quebec context, the CSSSs and FMUs have features making them key players in structuring the quest for quality.

6.5. STUDY LIMITATIONS

The study's limitations are specific to qualitative approaches: the number of participants is small compared to the total number of people concerned by the topic and the analysis focuses more on the nature of the remarks than on their scope in terms of generalization. Yet many specific conditions brought together in this project enhance the value of the results. Consequently, the participants were selected based on their interest in the topic or their desire to participate in these exchanges; they actively took part in the discussions. The small-group format enabled us to examine our topic from different angles by using the ideas of all the participants, on the one hand, and by providing the time needed for in-depth discussion, if required, on the other. The results were further enhanced with representation of all the main primary care practice settings, including an appreciable number of physicians (who are often considered as being difficult to involve), taking into account their various practice modes (FMUs, FMGs, private practices). The decision to limit representation of community organizations to those involved in crisis intervention was in line with the pan-Canadian project and its more clinical orientation. Lastly, one shortcoming that should be remedied in future work was the lack of representation of families and significant others. This was also true on the pan-Canadian level.

As for the material collected, the summaries of each group discussion were validated by at least 25% of participants, thereby confirming their faithfulness to the remarks made. The emphasis in processing our information was placed on convergences and singularities as well as on the degree of support of the settings for the remarks made. In this regard, we avoided focusing on the silence of setting representatives, since it is impossible to interpret this behavior within the context of the project. Although it is unusual in such processes, the results were communicated to all participants. This provided additional validation of the accuracy and legitimacy of the results in the eyes of those involved. Our constructivist approach enabled us to consolidate our foundations and to earn a degree of validity in the eyes of the main interested parties. Lastly, the involvement of an outside consultant enabled us to take a critical look at our results and process, and, as a result, add some new dimensions to them.

CONCLUSION

The pan-Canadian project entitled “Continuous Enhancement of Quality Measurement in Primary Mental Health Care: Closing the Implementation Loop” aims mainly at identifying a small set of quality measures reached by a consensus of the stakeholder groups from across Canada. This contribution has been perceived as a tangible means for improving the quality of primary care. Using such measures, however, requires generating awareness about them. In addition, the stakeholders involved must be mobilized on a smaller scale, such as provincial or even regional, in order to arouse their interest in these measures and lead them to apply them. In Quebec, the method for promoting this awareness was to involve the main health practice settings concerned by the primary mental-health care in the Quebec region in exploring quality in their practices. To do this, we used a constructivist approach based on a participatory and interactive methodology. This approach revealed that the main stakeholders are concerned about improving quality, but they view it as a dynamic and systemic process. The results of the Quebec study and their juxtaposition to the pan-Canadian process reveal:

- the diversity of primary care practice settings in Quebec and their common interest in better documenting quality with a view towards improving the quality of care and services;
- the diversity of the targets for potentially improving primary mental health care and services, which most often are common but sometimes unique;
- the importance of situating these different targets within a systemic reference framework to more clearly understand their complementarity and their specificity;
- the road leading to conditions conducive to the implementation of quality measures, both on the systemic and organizational levels;
- the presence of organizational players in a privileged position to play leadership roles in developing initiatives related to quality measurement;
- the additional work required to integrate the point of view of families and significant others into the process;
- the required recognition of the values on which the quest for quality is founded as well as putting them into perspective within a broader social context.

Moreover, the participants identified a number of areas of questioning pertaining to the quest for quality: the divergent concerns of managers and caregivers; the tension between relational continuity and collaborative practice; the limitations of instruments initially designed for administrative purposes; the limitations of measures taken one-by-one; and the challenges facing this quest for quality in a nearly continual context of change, when the stakeholders perceive an excess of work and a shortage of resources. These aspects span time and call for a specific reflection exercise conducted with a broad range of stakeholders.

Many activities are being planned to continue mobilizing Quebec stakeholders with respect to this issue. To illustrate, an activity will be carried out in September 2006 to communicate the final results of the pan-Canadian project to the individuals who were directly or indirectly involved in one or another of the project components. In 2007, special attention will be paid to provincial and regional opportunities for disseminating the project’s results. Lastly, there will be an opportunity to communicate these results on the provincial level to participants in a vast research project on implementing the provincial mental health action plan. Occasions will be created to publicize the project’s results through a component dealing with the sharing and exchange of knowledge. This is why 15 CSSSs throughout five regions as well as the Inuit and Cree territories will be specifically contacted. These various activities will ensure extensive circulation of the results and, we hope, will lead to the mobilization required for the follow-up of this project.

Researchers in the pan-Canadian project agreed to meet several times in the upcoming year on tangible follow-up to the project. Lastly, the project's main productions are available in both French and English on the project Web site (http://www.ceqm-acmq.com). The site also contains the 160 measures used in the last pan-Canadian survey, including succinct information about the sources used and the rating used to describe their scientific robustness.

REFERENCES

1. Institute of Medicine. (1992). Guidelines for clinical practice: from development to use. Washington, DC: National Academy Press.

2. Avis du Conseil Médical du Québec : Imputabilité médicale et gouvernance clinique : Bâtir sur la qualité et la performance des pratiques, septembre 2003, p. 24-25.

3. IOM, Crossing the Quality Chasm : A New Health System for the 21st Century, National Academy Press, Washington, D »C » ; 2001, p.20.

4. World Health Organization. (2003). Quality Improvement for Mental Health. Geneva, Switzerland: World Health Organization.

5. Canadian Council on Health Services Accreditation. A Guide to the Development and Use of Performance Indicators, Ottawa, 1996.

6. Barrett, J.E., Barrett, J.A., Oxman, T.E., Gerber, P.D. (1988) The prevalence of psychiatric disorders in a primary care practice, Archives of General Psychiatry, 45, 1100-6.

7. Tiemens, B.G., Ormel, J., Simon, G.E. (1996) Occurrence, recognition, and outcome of psychological disorders in primary care. American Journal of Psychiatry, 153, 636-44.

8. Waraich, P., Jones, W. (2003) Continuous Enhancement of Quality Improvement in Primary Mental Health Care: Closing the Implementation Loop, Project proposal, p.50, Figure 6: Physician Visits in B.C. for a Mental Health Diagnosis 1997/98, Age 15-64. Source: MHECCU, through a specific analysis of their linked data set. See http://www.sharedcare.ca/pdf/MHECCU_PHCTFApp2_FINAL.pdf

9. MSSS, (2005) Création de 95 centres de santé et de services sociaux (CSSS) au cœur des 95 réseaux locaux de services de santé et de services sociaux (RLS) Voir http://www.msss.gouv.qc.ca/reseau/rls/

10. Campbell, S.M., Roland, M.O., Buetow, S.A. (2000) Defining quality of care, Social Science & Medicine, 51, 1611-1625.

11. Kyle, T., Desai S., Wang J.L., Addington D. (2006), The Readiness to Implement Quality Measurement Checklist: Development and Pilot Testing, Department of Psychiatry, University of Calgary.

APPENDIX 1

GLOSSARY OF DIFFERENT TERMS USED IN THE PROJECT

APPENDIX 1: GLOSSARY OF DIFFERENT TERMS USED IN THE PROJECT

Best practices:

A snapshot of the current expert judgement and empirical evidence related to a particular aspect of health care.[1]

Consensus:

Consensus methods involve identifying areas of agreement in terms of health measures or health measure domains. Campbell[2] reviews a number of commonly used consensus methods, including: consensus development conferences, Delphi technique, nominal group technique, and the RAND appropriateness method. These methods often have specific technical guidelines to assist in determining whether agreement exists.

Health Quality Measure:

1) A standardized assessment which quantifies the extent to which an individual unit within a population (person in a clinic, individual clinic amongst all clinics in a region) meets some criterion for quality of care.[3]
2) A measurement tool, screen or flag that is used as a guide to monitor, evaluate and improve the quality of client care, clinical support services and organizational functions that affect outcomes.[4]

Practice-Level Health Quality Measure:

Measures focused on improving quality of care at the level of the consumer-provider interface.

Knowledge transfer:

The exchange, synthesis and ethically-sound application of knowledge within a complex system of interactions among researchers and users to accelerate the capture of the benefits of research for Canadians through improved health, more effective services and products, and a strengthened health care system.[5]

Mental health:

1) The capacity of the individual, the group and the environment to interact with one another in ways that promotes subjective well being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice, and the attainment and preservation of conditions of fundamental equality.[6]
2) Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. Mental health involves the following: a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.[7]

Primary Care:

1) A set of universally accessible first-level services that promote health, prevent disease, and provide diagnosis, curative, rehabilitative, supportive, and palliative services.[8]
2) First contact with the health system. It often takes place in physicians' offices or community health centres. It is the first step in the continuum of care, emphasizing health promotion and illness prevention.[9]
3) Primary care involves the following principles: universal access to care and coverage on the basis of need; commitment to health equity as part of development oriented to social justice; community participation in defining and implementing health agendas; intersectoral approaches to health.[10]

Primary Care Mental Health:

Treatment of mental health problems through primary care (for example, through a nurse or family doctor).

Primary Care Mental Health Quality Measures:

Standardized measures for use in primary care mental health services, used to facilitate quality improvement.

Quality of Care:

1) Whether Individuals can access the health structures and processes of care which they need and whether the care received is effective.[11]
2) Degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[12]
3) The total appropriateness of care as perceived by patients or professionals, including compliance with guidelines, as well as the suitability of services.[13]
4) The extent to which health services meet the specified goals and standards of the accepted norm for good care and health service. Quality in health care is judged by three key areas, namely structure, process, and outcomes.[14]

Quality Improvement:

1) A continuous process of striving for improved performance, involving problem identification, the testing of solutions and the monitoring of solutions on an ongoing basis.[15]
2) It increases the likelihood of desired health outcomes consistent with current professional knowledge on quality improvement.[16] It does not set standards, targets, assign blame, and typically involves self-comparisons over time.

Appendix 1 References:

1. Fischer et al. Quality Enhancement Research Initiative in Mental Health. Med Care. 2000 June; 38(6 Suppl 1): 170-81.

2. Campbell, S.M.; Braspenning, J.; Hutchinson, A., and Marshall, M. N. Research methods used in developing and applying quality indicators in primary care. BMJ. 2003 Apr 12;

326(7393.): 816-9; ISSN: 1468-5833.

3. Adapted from:http://www.qualitymeasures.ahrq.gov/resources/measure_use.aspx and Charlwood, P. et al. (1999). Outcome indicators: severe mental illness. Report of a Working Group. London: Department of Health.
4. Canadian Council on Health Services Accreditation. A Guide to the Development and Use of Performance Indicators, Ottawa, 1996.
5. Adapted from Canadian Institute of Health Research (CIHR): The Canadian Institutes for Health Research Knowledge Translation Framework.

   http://www.cihr-irsc.gc.ca/about_cihr/organization/knowledge_

   translation/kt_framewor_prelim_e.shtm#definition. Last accessed July 22, 2003; subsequently removed from CIHR site.
6. Health Canada. Striking a Balance. Ottawa, 1988.
7. WHO Web site July 15, 2004: http://www.who.int/mediacentre/factsheets/fs220/en/print.html
8. Canadian Health Services Research Foundation. Choices for change: The path for restructuring primary healthcare services in Canada. 2003 Nov.
9. Health Canada website July 15, 2004: http://www.hc-sc.gc.ca/english/media/releases/2001/2001_123ebk1.htm.
10. WHO Web site July 15, 2004: http://www.who.int/whr/2003/chapter7/en/index1.html
11. Campbell, S.M.; Roland, M.O., and Buetow, S.A. Defining quality of care. Soc Sci Med. 2000 Dec; 51(11): 1611-25.
12. Institute of Medicine. (1992). Guidelines for clinical practice: from development to use. Washington, DC: National Academy Press.
13. Canadian Health Services Research Foundation. Choices for change: The path for restructuring primary healthcare services in Canada. 2003 Nov.
14. Health Canada Web site July 15, 2004: http://www.hc-sc.gc.ca/hppb/healthcare/pubs/quest/introduction.html
15. World Health Organization. (2003). Quality Improvement for Mental Health. Geneva, Switzerland: World Health Organization.
16. Institute of Medecine. (1992). Guidelines for clinical practice: from development to use. Washington, DC: National Academy Press.

APPENDIX 2

LIST OF THE 81 DOMAINS SELECTED FOR THE FIRST SURVEY

APPENDIX 2: LIST OF THE 81 DOMAINS SELECTED FOR THE FIRST SURVEY

Process			
Acceptability	Accessibility	Appropriateness	Competence
Continuity	Effectiveness	Efficiency	Security
Comprehensivess	Patient-Centeredness	Legal Aspescts	
Outcome			
Health Conditions	Human Function	Well-Being	Deaths
Satisfaction		Impact on Society	
Structure			
Physical Infrastructure	Human Resources Management	Formation Management	Financial Ressources Management
Quality and Safety			
Non-Medical Determinants of Health			
Health Behaviors	Living and Working Conditions	Personal Resources	Environmental Factors
Literacy and Health			
Equity			

Specific condition					
P.With Comorbid Conditions	P.With Chronic Conditions	P.With Acute conditions	P.With Suvtance Abuse	P.With Anxiety Disorders	P.With Sleep disorders
P.With Eating disorders	P.With Personality Disorders	P.With Mood Disorders	P.With Psychosis	P.With Impulse Control Disorders	Mental Health Problems in Children
Mental Health Problems in Elders	Mental Health Problems Related to Pregnancy				
Special Groups					
Racial And Ethnic Minorities	Rural populations	Family History	Welfare Recipients	Homeless Or Itinerant	Unemployed
Aboriginal	Seniors in Facilities	Recent Refugees	Immigrants	Residents of Correctional institutions	Inner City Residents
English As a Second Language French As a Second Language					
Age Groups					
Elderly	Adults		Youth	Children	
Gender Groups					
Women		Men		Gender Identifiers Other Than Men or Women	
Interventions					
Medication	Psychotherapy	Prevention	Early Detection	Health Promotion	Family Involvement
Group Treatment	Self-Management support	Rehabilitation	Physical Health Intervention		
Clinical Setting					
Mental Health Shared Care	Emergency	Mental Health Services in Schools Settings	Mental Health Services in Working Settings	Services in The Community	Solo Practice
Group Practice	Community Mental Health center Walk-in Services				

APPENDIX 3

LIST AND DEFINITIONS OF THE 22 PRIORITY DOMAINS

APPENDIX 3: LIST AND DEFINITIONS OF THE 22 PRIORITY DOMAINS

SYSTEM-WIDE DOMAINS

System-Wide Domains include practice and measures that are applicable across a variety of people with different conditions, in varying clinical settings.

DIMENSION*	**DOMAIN**	**DEFINITION**
Process	Accessibility	Clients/patients are able to obtain care/service at the right place and the right time, based on respective needs. *Examples*: waiting times, physician availability.
	Patient-Centeredness	Establishing a partnership among practitioners, patients and their families (when appropriate) to ensure that decisions respect patients' wants, needs and preferences. Patients have the education and support they need to make decisions and participate in their own care. *Examples*: facilitating meetings between providers, patients and their families when desired; education sessions for self-management of health conditions.
	Competence	The care provider's knowledge and skills are appropriate to the care/service being provided. *Examples*: providers are knowledgeable about the use of evidence based psychotherapy and about techniques to improve quality of care.
	Continuity	Services are offered as a coherent and coordinated succession of events in keeping with the health needs and personal context of patients. Health care is linked to other services to support successful treatment. *Examples*: making contact with patients after missed appointments; referring patients to peer support groups.
	Effectiveness	The care / service, intervention or action achieves the desired results. *Examples*: improved mood, decreased readmission rate for psychosis.
	Appropriateness	Care/service provided are relevant to the patient's needs based on established standards. *Examples*: medication prescriptions based on established standards.
Outcomes	Health Conditions	Changes to or the characteristics of the health status of an individual (including symptom severity) which may lead to distress, interference with daily activities, or contact with health services. *Examples*: depression, stress.
Non-medical determinants of health system-wide domain	Personal Resources	Characteristics of personal life, such as social support, life stress and school readiness as they are related to health.
	Equity	Individuals get the care they need, without inappropriate bias based on their social status or other personal characteristics such as age, gender, ethnicity or place of residence.

* Dimensions are wider than domains and capture more global aspects of health systems.

SPECIAL AREA DOMAINS

Special Area Domains include practices and measures targeting specific clinical populations, special groups, and clinical settings. These domains can interact with each other, and may also be applied to system-wide domains.

DIMENSION*	**DOMAIN**	**DÉFINITION**
Specific Age Groups	Youth	Young people, 12 to 19 years of age.
Specific Clinical Settings	Shared Care	Collaborations between providers from primary care and mental health disciplines who share the responsibility for the care an individual receives.
	Community Health Care Centre	Health care delivered by a multidisciplinary team of providers and specialists, typically offering services to a geographic area or special population.
	Emergency Medical Services	A hospital room or mobile crisis response unit equipped for the reception and treatment of persons requiring immediate medical care.
	Outreach Services	Services providing primary care in non-traditional settings which are more accessible to vulnerable populations. *Examples:* home-based care, assertive community treatment teams, street nurses.
Specific Interventions	Early Detection	Diagnosis and initiation of treatment at a very early stages of the disease, when little or minimum interventions can bring therapeutic results. *Example:* within the first two years of illness.
	Psychotherapy	Treatment of mental and/or emotional problems using psychological techniques. *Examples*: cognitive-behavioural therapy or talking therapy
	Rehabilitation	Restoration of a person, by therapeutic measures and re-education, to participation in the activities of normal life within the limitations of the person's disorder or disability.
Specific Conditions	Psychosis	A serious mental disorder (such as schizophrenia) characterized by defective or lost contact with reality often with hallucinations or delusions. *Example :* schizophrenia.
	Child Mental Health Disorders	Mental health disorders common in children and youth. *Examples:* conduct disorder, autism, attention deficit disorder, obsessive-compulsive disorder.
	Acute Conditions	Patients whose conditions require an immediate medical intervention. *Example:* emergency room visit.
	Comorbid Conditions	Situation in which a person has both a major mental illness and another health problem. *Examples:* developmental disability, substance abuse, personality disorder, or other general medical conditions such as heart disease or cancer.
	Mood Disorders (or Affective Disorders)	Any of several psychological disorders characterized by abnormal emotional states such as major depressive disorder and bipolar disorder.

* Dimensions are wider than domains and capture more global aspects of health systems.

APPENDIX 4

PARTICIPATION FROM QUEBEC FOR EACH STAGE OF THE PAN-CANADIAN PROJECT

APPENDIX 4: PARTICIPATION FROM QUEBEC FOR EACH STAGE OF THE PAN-CANADIAN PROJECT

First Stage

Twenty-four individuals from Quebec were invited to take part in the three activities under stage one: a 90-minute information session on project description and stage-one organization (September 21-24, 2004); response to the self-administered written survey (October 2004); and a focus group on the preliminary results (December 15, 2004 and January 13, 2005). As the result of one refusal and two withdrawals, only 21 representatives from Quebec took part in stage one. Table 5 provides their origin and status[8].

Table 5: Origin and status of respondents in the first survey

STAKEHOLDER CATEGORY (N = 21)	ORIGIN	STATUS
Managers and planners (8)	Ministère de la Santé et des Services sociaux (MSSS)	• Assistant to the provincial head of mental health
	Laval University	• Director, family medicine program for eastern Quebec
	Regional authority	• Head, mental health services • Head of mental health, Département régional de médecine générale
	Community	• Director, Centre de crise de Québec
	Urban CSSS	• Director, Professional Services • Assistant Director, Adult Sector, Basic Mental Health and Social Services
	Family medicine group (FMG)	• Physician in charge
Clinicians (7)	Family medicine group	• Nurse
	Urban CSSS	• Physician • Social worker • Nurse
	Private practice and family medicine unit (FMU)	• Physician
	School setting	• Psychologist
	University hospital	• Psychiatrist
User representatives (6)	• Former president, community organization • User committee • Community organizations (3) • CSSS (member of a territorial issue table)	• General public • Users

---

[8] Project participants waived confidentiality of their identities (consent form). This accounts for the fact that it is sometimes possible to deduce the identity of certain participants from the tables describing participation during the various project stages.

Second Stage:

Seven experts (17%) from the 41 participating in the second stage came from Quebec:

- two clinicians (general physician practicing in a CSSS and general physician/epidemiologist practicing in a psychiatric hospital),
- one manager (CSSS in a semi-urban area),
- four researchers (representing McGill, Montreal and Sherbrooke universities).

Third Stage

In Quebec, 48 out of the 53 solicited agreed to take part: 44 out of 48 (92%) completed the first questionnaire; 31 the second. Table 6 gives the origins of the 44 participants.

Table 6: Origin of respondents in the third survey

STAKEHOLDER CATEGORY (N = 44)	ORIGIN (N)
Researchers (9)	Four Quebec universities (9): • Expertise in mental health, service organization, rehabilitation
Managers and planners (18)	Central Level (4): • MSSS and provincial organizations
	Supraregional Level (2): • Trainers in family medicine for the eastern part of the province
	Montréal Region (3): • CSSS, extended-care hospital, public-health department of the regional authority
	Quebec Region (9): • CSSS, regional authority, family medicine group, psychiatric hospital, community organization
Clinicians (11)	Professional orders (4): • Medicine, nursing, social work, and psychology
	Quebec Region (7): • CSSS: nurse, social workers, family physician, community-health medical specialist. • University hospital: Psychiatrist • Schools: psychologist • Private practice: physician
User representatives (6)	• Chair of a provincial agency (1) • Users (4) • General public (1)

APPENDIX 5

DESCRIPTION OF THE THREE CLINICAL VIGNETTES

APPENDIX 5: DESCRIPTION OF THE THREE CLINICAL VIGNETTES

1st Case History

Occasional Mental Health Need

- Psychosocial crisis in adult in the separation process, experiencing multiple stresses (precarious job, change of residence). He is very destabilized, everything is going wrong, everything has been disrupted.
- He decides to consult.

2nd Case History

Need for Follow-up on the Medium Term

- Student 20 to 25 years of age.
- Over the last several weeks, he has not slept well, lost weight, had trouble attending class, lost interest, and consumed more alcohol (depression).
- Consults a physician because encouraged to do so by family and friends.

3rd Case History

Need for Follow-up on the Long Term

- Adult living alone diagnosed with schizophrenia.
- Stabilized mental illness, but has physical health problems (diabetes) and smoking.
- Has just moved to the area; the psychiatrist suggested follow-up in primary care.

Questions Submitted to Participants

- Given this user's needs and/or expectations, what do you feel are the elements to be considered in talking about quality of care and services delivered?
- What domains in this scenario challenged you or make more sense to you in terms of quality?

APPENDIX 6

ASSESSMENT GRID

APPENDIX 6: ASSESSMENT GRID

Rate this Activity

Presentations	++	+	-	- -
The presentation on the pan-Canadian component was clear.	○	○	○	○
The presentation on the regional component was clear.	○	○	○	○
The first part of the results was clear.	○	○	○	○
The second part of the results was clear.	○	○	○	○

Conduct of the 1st Workshop	++	+	-	- -
The themes were relevant.	○	○	○	○
The facilitation was adequate.	○	○	○	○
I learned a great deal about the other settings through the exchanges.	○	○	○	○
The workshop gave me ideas to act on quality in my setting.	○	○	○	○

Conduct of the 2nd Workshop	++	+	-	- -
The themes were relevant.	○	○	○	○
The facilitation was adequate.	○	○	○	○
I learned a great deal about the other settings through the exchanges.	○	○	○	○
The workshop gave me ideas to act on quality in my setting.	○	○	○	○

+ +	I completely agree with the statement.
+	I somewhat agree with the statement.
-	I somewhat disagree with the statement.
- -	I completely disagree with the statement.

Comments:

Overall Assessment of the Day	++	+	-	- -
This activity met my expectations.	○	○	○	○
I am satisfied with how the activity was organized.	○	○	○	○
Adequate time was allocated.	○	○	○	○
Satisfactory interactions with the presenter.	○	○	○	○
Satisfactory interactions between the participants during the workshops.	○	○	○	○
The analysts' remarks and interventions were apt.	○	○	○	○
The outside analyst's remarks were inspiring.	○	○	○	○
I am satisfied with the documentation handed out.	○	○	○	○
The audiovisual support was adequate.	○	○	○	○
The material and physical conditions of the site were adequate.	○	○	○	○

+ +	I completely agree with the statement.
+	I somewhat agree with the statement.
-	I somewhat disagree with the statement.
- -	I completely disagree with the statement.

What important points did you take away from this activity?

If another activity on the theme of quality were to be held in the fall, what would you suggest?

APPENDIX 7

RESULTS OF THE ASSESSMENT GRID

APPENDIX 7: RESULTS OF THE ASSESSMENT GRID

Results of the Assessment Grid for May 12

Number of sheets: 38

Presentations	**++**	**+**	**-**	**- -**	**N/A**
The presentation on the pan-Canadian component was clear.	29	7			2
The presentation on the regional component was clear.	29	8			1
The first part of the results was clear.	22	13			3
The second part of the results was clear.	20	14			4
Conduct of the 1st Workshop	**++**	**+**	**-**	**- -**	**N/A**
The themes were relevant.	28	9			1
The facilitation was adequate.	25	11	1		1
I learned a great deal about the other settings through the exchanges.	20	12	5		1
The workshop gave me ideas to act on quality in my setting.	15	16	6		1
Conduct of the 2nd Workshop	**++**	**+**	**-**	**- -**	**N/A**
The themes were relevant.	32	6			
The facilitation was adequate.	31	7			
I learned a great deal about the other settings through the exchanges.	30	7			1
The workshop gave me ideas to act on quality in my setting.	23	12		2	1
Overall Assessment of the Day	**++**	**+**	**-**	**- -**	**N/A**
This activity met my expectations.	20	15			3
I am satisfied with how the activity was organized.	30	6			2
Adequate time was allocated.	28	7			3
Satisfactory interactions with the presenter.	27	8	1		2
Satisfactory interactions between the participants during the workshops.	25	11			2
The analysts' remarks and interventions were apt.	24	11	1		2
The outside analyst's remarks were inspiring.	30	5			3
I am satisfied with the documentation handed out.	27	8	1		2
The audiovisual support was adequate.	29	7			2
The material and physical conditions of the site were adequate.	31	5			2

APPENDIX 8

READINESS TO IMPLEMENT THE QUALITY MEASUREMENT CHECKLIST

APPENDIX 8: READINESS TO IMPLEMENT THE QUALITY MEASUREMENT CHECKLIST

Authors: Tania Kyle, Soni Desai, Jian Li Wang & Donald Addington
Department of Psychiatry, University of Calgary

Completing the checklist will provide practical information about your organization’s readiness to do quality measurement. The outcome is not a ‘readiness score’, but rather a starting point for discussion and planning. The checklist statements are organized into categories that prompt you to assess your organization in terms of its stage of planning for quality measurement, the characteristics and promotion of the quality measures, implementation strategies, available resources, staff readiness, operational readiness and external factors.

Quality measures (or quality indicators) are norms, criteria, standards, and other direct qualitative and quantitative measures used in determining the quality of health care. Examples include: ‘the percentage of mental health clinicians with appropriate skills in cognitive behavioral therapy’ and ‘the percentage of patients being treated for depression receiving the appropriate dosage and duration of treatment for antidepressants’.

Instructions: Read each statement and indicate your response with a check mark. Complete the checklist based on your perspective in the organization. Try to respond to every statement with an answer of yes, no, or N/A (not applicable).

What are your organization’s plans regarding quality measurement?	**Yes**	**No**	**N/A**
1. Has no plans to implement quality measurement.			
2. Intends to implement quality measurement in the next 6 months.			
3. Intends to implement quality measurement in the next 30 days.			
4. Has been using quality measures for a short time (less than 6 months).			
5. Has been using quality measures for 6 months or longer.			
If you checked YES for statements 2 or 3, please complete the remainder of the checklist. Otherwise, you may stop now.			
What are the characteristics of the Quality Measures you wish to implement?			
A1. The measures are evidence based.			
A2. The terms comprising the measures have recognized definitions.			
A3. The measures have recognized norms/benchmarks.			
How are the Quality Measures being promoted?			
B1. The measures are published in a respected source.			
B2. The measures are endorsed by a credible source, such as physician licensing body or professional association.			
B3. Measures are promoted as an efficient solution to quality assurance.			
B4. Quality measurement is promoted through the use of incentives.			
B5. The measures are championed by a leader.			
B6. Local stakeholders participated in adapting measures to local circumstances.			
What implementation strategies are available to your organization?			
C1. Collecting measurement data is part of documenting care.			
C2. The measures are kept to the minimum number necessary.			
C3. There is an implementation plan to follow.			
C4. Academic detailing/outreach by a trained professional.			
C5. Practice based group learning with a facilitator and a specialist.			
C6. A consultant is available to help the staff to implement the measures.			
Which statements BEST describe your organization’s resources?	**Yes**	**No**	**N/A**
D1. The office has internet access.			
D2. The office computer system can support an Electronic Health Record.			
D3. Documentation is compatible with the Electronic Health Record.			
D4. There is a budget for quality improvement activities.			
D5. There is a staff member with quality measurement skills.			
D6. Using quality measures does not add extra time or work load to staff.			
Which statements BEST describe the individuals in your organization?			
E1. Staff comply with the current documentation method.			
E2. Staff have good computer skills.			
E3. Physicians adhere to practice protocols.			
E4. Physicians think measures could be used to monitor and reward good performance.			
E5. Physicians believe implementing measures will lead to improved practice.			
E6. Quality measurement is a personal interest of a staff member or physician.			

Which statements BEST describe the current operation of your organization?
F1. There is positive leadership in the organization.
F2. The decision making authority is clear.
F3. Organization leaders understand the impact of their decisions on patient care.
F4. Clinicians from different professional groups work as a team.
F5. Physicians are able to allocate time for quality measurement activities.
F6. Frontline staff is involved in planning for change or innovation.
F7. There is team agreement on the purpose and benefits of quality measures.
F8. There is a staff member who is responsible for data entry.
Which of these external factors affect your organization?
G1. There is a shortage of specialists for timely mental health referrals.
G2. The political environment is open to new healthcare innovations.

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Reference:

Kyle, T., Desai, S., Wang, J.L. & Addington, D. (2006). The facilitators and barriers to implementing quality measurement in primary mental health care: A systematic review.

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Appendix 8 bibliography :

1. Barrett, J.E., Barrett, J.A., Oxman, T.E., Gerber, P.D. (1988) The prevalence of psychiatric disorders in a primary care practice, *Archives of General Psychiatry*, 45, 1100-6.
2. Campbell, S.M., Roland, M.O., Buetow, S.A. (2000) Defining quality of care, *Social Science & Medicine*, 51, 1611-1625.
3. Goldner, E., *Synthesis Series: Mental healthcare, Health Transition Fund*, 2002, http://www.hc-sc.gc.ca/htf-fass/english/mental_en.pdf
4. Kyle, T., Desai S., Wang J.L., Addington D. (2006), *The Readiness to Implement Quality Measurement Checklist: Development and Pilot Testing*, Department of Psychiatry, University of Calgary.

5. Tiemens, B.G., Ormel, J., Simon, G.E. (1996) Occurrence, recognition, and outcome of psychological disorders in primary care. *American Journal of Psychiatry*, 153, 636-44.

6. Waraich, P., Jones, W. (2003) *Continuous Enhancement of Quality Improvement in Primary Mental Health Care: Closing the Implementation Loop*, Project proposal, p.50, Figure 6: Physician Visits in B.C. for a Mental Health Diagnosis 1997/98, Age 15-64. Source: MHECCU, through a specific analysis of their linked data set. See http://www.sharedcare.ca/pdf/MHECCU_PHCTFApp2_FINAL.pdf

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