INFO-SANTÉ: A BRIEF HISTORY OF TELEPHONE HEALTH CARE CONSULTATION IN THE EASTERN TOWNSHIPS

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ABSTRACT

The Quebec health care system's *virage ambulatoire* saw the creation of a number of new services designed, in part, to take up the some of tasks of traditional medical and nursing services. In the Eastern Townships, the creation of Info-Santé coincided with the closure of Sherbrooke Hospital and was closely followed by the closure of Hôpital Saint-Vincent-de-Paul. Info-Santé is a front-line telephone nursing service providing 24/7 health information, triage and referrals for callers throughout Quebec. This article traces the service's history and evolution in the Eastern Townships.

RÉSUMÉ

Le virage ambulatoire qu'a connu le système de santé québécois a permis la mise en place de plusieurs nouveaux services dont l'objectif était, en partie, de prendre en charge certaines tâches habituellement accomplies par les services médicaux et de soins infirmiers traditionnels. Dans la région des Cantons-de-l'Est, la création du service Info-Santé coïncide avec la fermeture de l'Hôpital de Sherbrooke, suivi de près par la fermeture de l'Hôpital Saint-Vincent-de-Paul. Info-Santé se veut un service de soins infirmiers téléphoniques visant à offrir à la clientèle régionale des renseignements médicaux vingt-quatre heures par jour, sept jours sur sept, et à faciliter les opérations de triage et de références médicales pour l'ensemble des Québécois. Cet article retracera donc l'histoire et l'évolution de ce service dans les Cantons-de-l'Est.

Introduction

How does a population learn health self-care strategies? How do people know where to turn when they or a loved one is ill? How do they know where to go to consult a physician for a health

problem? How do they know when the problem is serious enough to require a physician's intervention? In the past, many turned to their family members, neighbours or friends for quick access to health care information. In the rural settings of the Townships, they would perhaps pick up the telephone and call their local general practitioner for advice. The general practicioner would listen to the caller, evaluate the problem and decide if she or he needed to head out to see the person at her/his home or if the person could wait until the next day and come to her/his office to be evaluated in person. Or perhaps she/he would tell the person that the problem was simple enough for the person and her/his family to manage at home, and would offer care suggestions. She/he might only listen, providing a supportive role for an anxious person on the other end of the line. Only in the direst of situations would the general practitioner suggest going to the hospital.

With the passage of time and the advent of Medicare, much has changed. Medical care has become much more sophisticated; general practioners are less willing to sacrifice their private lives to the demands of patients at all hours of the day and night. Indeed, it is noteworthy that the number of "family doctors grew from 95 to 98 per 100,000 population from 2001 to 2007. Yet the percentage of people with a regular family doctor fell from 88% to 85% nationally, ranging from 74% in Quebec to 93% in Nova Scotia in 2007" (CIHI, 2009, 65). As a population we seem to have a clearer idea of what we want from physicians, we seek to be more engaged in our own treatment and are "less tolerant of mild symptoms and relatively benign problems" than we were in the past (Guadagnoli and Ward, 1998; Barsky and Boros, 1995 as cited in Conrad, 2007, 46). We want fast relief from pain or discomfort, immediate attention for our problems, and we want all the latest tests to confirm our own or our doctor's suspicions. We have become health care consumers and we expect the health care market to perform like any other marketplace (Conrad, 2007).

These particular changes were coupled with an ideological shift in thinking concerning the traditional medical model of delivering health care. Furthermore, political pressures to reduce health care spending, with a move away from the hospital setting and toward more ambulatory care (known in Québec as the *virage ambulatoire*) became an important preoccupation at the government level. All of these upheavals in Quebec's health care system resulted in the creation of Info-Santé (CSSS-IUGS, 2006; Gouvernement du Québec – Ministère de la Santé et des Services sociaux : Direction générale des

programmes, 1994; Gouvernement du Québec – Ministère de la Santé et des Services sociaux : Direction générale des programmes et Direction générale des services de santé et de médecine universitaire, 2007). The purpose of this article is to trace the evolution of the Info-Santé service in the Eastern Townships.

Methods

Primary, unpublished documents obtained through the Info-Santé Centrale-Estrie were used to trace the specifics of the service's history in the Eastern Townships. Government documents from the Ministère de la Santé et des Services sociaux : Direction générale des services sociaux et Direction générale des services de santé et de médecine universitaire were also consulted to provide an overview of the service's evolution in the provincial context. Secondary sources from within the field of the Sociology of Health and Illness provided sociological, scholarly evidence for the author's claims.

Discussion

The shift toward ambulatory care was a consequence, at least in part, of neoliberal ideology. In the early 1990s, the federal government followed other OEDC countries in seeking to reduce substantial deficits to deal with a weakening economy by decreasing public spending in general and by transferring health and social service to the provinces in particular (CIHI, 2009; Detsky et al. 2003). The period of early- to mid-nineties (1992-1996) saw an actual reduction in health care investment: "In 1992, health care consumed 10% of the gross domestic product (GDP). By 1996, it had fallen to 8.9% and would not reach 10% again until 2002" (CIHI, 2009, 18). Indeed, cash transfers from federal to provincial governments decreased on average from "30.6% in 1980 to 21.5% in 1996" (Detsky et al., 2003, 805). This, in turn, forced provincial governments to slash health spending and seek alternatives to costly hospital stays in order that they, too, could balance "their budgets and […] pay down their debt" (CIHI., 2009, p. 19; Detsky et al, 2003, 805).

Info-Santé is a 24/7 nursing telephone service offered through the CSSS (Centre de santé et de services sociaux – initially known as CLSC) system, providing health and referral information. Its history in the Townships dates back to September 14, 1995 with the opening of its services in Sherbrooke, but the concept of Info-Santé within the province of Quebec goes back to 1981 (CSSS-IUGS, 2006;

Gouvernement du Québec – Ministère de la Santé et des Services sociaux: Direction générale des programmes et Direction générale des services de santé et de médecine universitaire, 2007). Though this article will focus on the service's evolution in the Eastern Townships, a brief sketch of its evolution within the province provides a useful context.

In 1981, a similiar type of service was initiated in Montreal as part of the access to ambulance emergency services. The Pope's visit to Quebec City in 1984 and the advent of the visit of the Tall Ships that same year saw the initiation of a telephone referral centre developed in Quebec to respond to the anticipated health and reference needs of the large number of visitors to the city. Following these two important events, the service was expanded and refined. In 1991, the Ministère de la Santé et des Services sociaux du Québec (MSSS) approved the dissociation of Info-Santé services from those of the ambulance service, Urgences-Santé (CSSS-IUGS, 2006; Gouvernement du Québec – Ministère de la Santé et des Services sociaux : Direction générale des programmes et Direction générale des services de santé et de médecine universitaire, 2007).

The official opening of Info-Santé Montréal took place in 1992 and was followed by similiar openings across the province. The principal functions of the newly created Info-Santé service as laid out in the 1994 "Cadre de Référence" were: "l'accueil/évaluation, l'information/conseil, et l'orientation/référence" (in English: initial contact/evaluation, information/advice, and orientation/reference) (14-15).

As noted above, the opening of the Centrale Info-Santé Estrie in Sherbrooke took place on September 14, 1995. By the end of 1996, each CLSC in the province offered the Info-Santé service. This includes each of the seven CLSCs that make up the Estrie 05 territory, namely, Asbestos, Coaticook, Haut-St. François, Granit, Memphrémagog, Sherbrooke (which itself was initially composed of two separate CLSCs – Gaston- Lessard and SOC), and Val St. François (Gouvernement du Québec – Ministère de la Santé et des Services sociaux: Direction générale des programmes et Direction générale des services de santé et de médecine universitaire, 2007; Info-Santé CLSC, 2002).

Coinciding with the birth of Info-Santé services came the closure of two active care facilities located in Sherbrooke which had long served the entire Eastern Townships. July 1995 saw the merger of the Centre Hospitalier Universitaire de Sherbrooke, Hôpital Saint-Vincent-de-Paul and Hôpital Hôtel Dieu as a new entity under the

name of the Centre Universitaire de Sherbrooke, or CHUS. April 1st, 1996 saw the merger of Sherbrooke Hospital with d'Youville, a local geriatric centre, to become the Institut Universitaire de gériatrie de Sherbrooke, the IUGS. This was closely followed by the complete closure of what was by then known as the Pavillion Saint-Vincent of the CHUS in 1997. These major restructuring efforts saw the number of acute hospital care beds in the city of Sherbrooke reduced to 720 from the 1200 beds under the previously existing sturctures. The expected savings over the following three years was predicted to be 20 million dollars (*The Stanstead Journal*, January 24, 1996, 17). The need for a service providing health information and referrals was of growing importance to serve a population now confused as to where to turn to seek services.

From its inception in 1995, a "centralized/decentralized" model of the Info-Santé service was used in the Estrie region. This model allowed for the local provision of the service by each of the seven CLSCs mentioned above during regular weekday hours (from 8:30 a.m. to 4:30 p.m. – Monday to Friday). All evening, nighttime and weekend and holiday service was provided by the Sherbrooke Centrale office. This practice freed the local, individual CLSCs from the responsiblity of providing the service 24/7 on site, while still allowing its citizens access to the service on a continual basis (Info-Santé CLSC – Bilan des opérations 2001-2002, 2002).

Shortly after the initiation of the service in the Estrie region, Info-Santé also became first responder for Urgences Détresse after 4:30 p.m. weekdays and for all weekend and holiday services for each of the CLSCs in the 05 Estrie Region. This social service component of the CLSC deals with calls of an urgent nature such as suicide attempts, abuse/violence, emergency housing, to name a few. As was the case initially with health calls, such social service calls continue to be handled locally by each CLSC during regular weekday hours. The service also responds to after-hour callers to the suicide prevention service, JEVI. Such calls are directed to on-site or on-call social workers or psychologists after an initial evaluation of the client's needs by the Info-Santé nurse. The Sherbrooke Centrale was one of the first in the province to initiate such a joint health and emergency social service undertaking (Info-Santé CLSC – Rapport annuel 2002–2003, 2003).

Over the course of the next several years, contracts between various CLSCs in the region and the Centrale allowed for the transfer of calls during specific periods (during the lunch hour, for example). Slowly, these contracts expanded in scope and became the norm. In

2000, the CLSC Val St. François contracted the entirety of its Info-Santé service to the Sherbrooke Centrale. By the end of 2002, most calls, day and night, from the Haut St. François and Memphrémagog CLSCs were being responded to by the Sherbrooke Centrale Info-Santé (Info-Santé CLSC –Rapport annuel 2002-2003, 2003).

This notable increase in the transfer of calls from the various CLSCs to the Centrale led to ongoing discussions concerning the eventual centralization of the service (Info-Santé CLSC –Bilan des opérations 2001-2002. October 2002). A variety of reasons lay behind these transfers of calls to the centralized office. As mentioned above, CLSCs normally operate during daytime hours only, although some services are available until 9 p.m. The volume of calls at the initiation of the service was quite low, allowing individual CLSCs to assign Info-Santé duties to nursing staff already assigned to other nursing tasks, for example, appointments with patients to change dressings. From logistical, efficiency and human standpoints, leaving a patient to answer a phone call was problematic and became more so as the volume of calls increased. The Centrale also allowed for more uniformity of responses. Since its nurses were not required to do tasks other than respond to calls, nurses working at the Centrale gained experience in addressing the wide variety of requests made by the callers, allowing for the evolution of Info-Santé as a new nursing speciality. The centralization of all Info-Santé services in the Estrie region was effective on a 24/7 basis as of April 1st, 2002 (Info-Santé CLSC – Rapport annuel 2002-2003, 2003).

Since that time, the service has continued to evolve. Ties to the Santé Publique have been close since the inception of the service and form a critical component of the initial and ongoing mandate of the service (Cadre de référence, 1994 and 2007). These important links allow for the shared surveillance of potential patterns in emerging public health problems, such as cyanobacteria-associated symptoms (blue-green algae), clusters of infectious diseases, food or water intoxication/contamination difficulties and planned responses, to name but a few.

The service also has historically linked CLSC home care clients with nursing or medical services should sudden changes in client needs arise. With the establishment of GMFs (*groupe de médecine de famille* – family medicine group) in the area in 2002-2003, Info-Santé took on the role of responding to callers requiring after-hour medical services as well as responding to registered vulnerable

clients' needs in a number of specific nursing residences, advising and/or linking these with appropriate nursing or medical services (Info-Santé CLSC – Rapport annuel 2002-2003, 2003).

By 2006, further restructuring of health resources within the region had seen the merger of the now-combined CLSC de la Région Sherbrookoise with the Institut Universitaire Gériatrique de Sherbrooke, under yet another new acronym/name, CSSS-IUGS or the Centre de santé et de services sociaux - Institut universitaire de gériatrie de Sherbrooke.

The Centrale Info-Santé de l'Estrie was designated in 2005-2006 as one of four centres in the province to serve English-speaking callers by the Ministère de la Santé et des Services sociaux du Québec. This designation allowed for investment in intensive English-language training for nurses as the Ministère prepared to implement Info-Santé services first under a province-wide automatic distribution of calls and, second, under a single province-wide access number. To this point, English-language calls to the service in the Estrie Region had been hovering consistently below 1.43% of all calls received, and representing only a very small proportion of the English-speaking population of the area (Info-Santé CLSC, 2002, 2003, 2004; Info-Santé Centrale Estrie, 2006).

By the end of January, 2007, the Estrie Region Centrale was "virtualized", the technical term used to allow for the automatic distribution of calls across the fifteen other Info-Santé Centrales in the province, according to waiting times in each of the various areas. This required a number of web-based technologies and an intricate telephone system to be set in place during 2006 (Info-Santé Centrale Estrie, Rapport Annuel 2006-2007, 2007). This "virtualization" spelled the end of Info-Santé services provided *for* the Eastern Townships' residents, *by* the nurses located at the Sherbrooke Estrie Centrale. Until the advent of virtualization, all calls originating from Townships' callers were answered within the region. The distinct advantage for both callers and nurses of shared "local knowledge" of services, institutional and community memories and local geography became less available.

In June 2008, a single access number, 811, was established to allow the Quebec population access to an Info-Santé nurse anywhere in the province. The service continues to evolve, with the addition of Info-Social, the social service component of the virtualization process now in effect in the Estrie Region after 4:30 p.m.; the caller is now able to choose Info-Santé or Info-Social with the push of a button. Within the not-too-distant future, this service will be

available province-wide on a 24/7 basis. At the time of this writing, local CSSS social service personnel continue to treat weekday calls between 8:30 a.m. and 4:30 p.m. (Info-Santé Centrale Estrie, Rapport annuel 2008–2009, 2009).

Info-Santé, as a provincial service, now handles about 2,400,000 calls per year; in the fiscal year 2008–2009, Info-Santé Centrale Estrie responded to 113,379 calls (Info-Santé Centrale Estrie, Rapport annuel 2008–2009, 2009). Numbers of calls are dramatically affected by local, provincial, national or global health concerns such as the recent H1N1 influenza pandemic, during which average weekly calls answered by the Centrale Estrie jumped from 400 to 1600 (Info-Santé, 2009).

Caller satisfaction studies have shown satisfaction rates above 90% (Hagan, 2001). Whether such rates would be found if similar studies were done today is an area for further research. Success of the service does, however, depend on continual updating of relevant information from the various health network partners. As one might expect, this is an ongoing challenge, particularly in light of rapidly developing situations.

Conclusion

Info-Santé is not the family practitioner at the other end of the telephone line as in days gone by. It does, however, replicate some of the same information and referral features, in addition to a multitude of services that the family general practitioner of the past could not possibly have imagined. The 24/7 service offered by specially trained nurses provides many people with an important and timely intervention in an era where family doctors, health services, and basic, general knowledge of health issues are unavailable, difficult to access or lacking easy interpretation. The ease with which an Info-Santé call can be placed thus responds to many of the new health care 'consumer' needs in the Eastern Townships and throughout the province. Despite this, many questions remain. Among these, it is imperative to ask what has been lost, by both callers and nurses, as face-to-face encounters between health professionals and those who seek answers to health concerns are replaced with a 'virtual' version of the professional consultation. Indeed, this question, among others, is central to this author's ongoing research into the sociology of such virtual consultations.

WORKS CITED

Bourque, Maryse, (2008) "Le traitement des appels urgents à Info-Santé," *Première Ligne* Vol. XXII, (2): 38–42.

Canadian Institute for Health Information, (2009) *Health Care in Canada 2009: A Decade in Review*. Ottawa: CIHI.

Conrad, Peter, (2007) *The Medicalization of Society,* Baltimore: The Johns Hopkins University Press.

Detsky, Allan S. and C. David Naylor, (2003) "Canada's Health Care System – Reform Delayed" *New England Journal of Medicine* 349(8): 804–810.

CSSS-IUGS de Sherbrooke – *Central Régionale 05 Estrie* (2006) internal document: Power Point presentation, unpublished.

Getting Our Money's Worth – Report of the Task Force on the Funding of the Health System – Summary, (February 2008) Bibliothèque et Archives nationals du Québec, Gouvernement du Québec, ISBN: 978-2-550-52161-7.

Gouvernement du Québec – Ministère de la Santé et des Services sociaux : Direction générale des programmes, (1994) *Accessibilité Continue 24/7 – Service Téléphonique Cadre de Référence*. Dépôt légal: Bibliothèque national du Québec, ISBN 2-550-29255-3.

Gouvernement du Québec – Ministère de la Santé et des Services sociaux : Direction générale des services sociaux et Direction générale des services de santé et de médecine universitaire, (2007) *Services Info-Santé et Info-Social – Cadre de Référence sur les aspects cliniques de volets santé et social des services de consultation téléphonique 24 heures, 7 jours à l'échelle du Québec*. Dépôt légal : Bibliothèque et Archives nationales du Québec, Bibliothèque et Archives Canada, ISBN : 978-2-550-51066-6 (PDF version).

Hagan, Louise et al., (2001) "Evaluation of Telenursing Outcomes: Satisfaction, Self-Care Practices, and Cost Savings," *Public Health Nursing* Vol. 17 (4): 305–313.

Info-Santé CLSC –*Bilan des opérations 2001–2002*. October 2002. Internal document : unpublished.

Info-Santé CLSC – *Rapport annuel 2002–2003*. November 2003. Internal document : unpublished.

Info-Santé CLSC – *Rapport annuel 2003–2004*. June 2004. Internal document : unpublished.

Info-Santé Centrale-Estrie – *Rapport annuel 2005–2006*. May 2006. Internal document: unpublished.

Info-Santé Centrale-Estrie – *Rapport annuel 2006–2007*. May 2007. Internal document: unpublished.

Info-Santé Centrale-Estrie – *Rapport annuel 2007–2008*. July 2008. Internal document: unpublished.

Info-Santé Centrale-Estrie – *Rapport annuel 2008–2009*. June 2009. Internal document; unpublished.

Levasseur, Hélène and Mariette Montecino, (2008) "Les Services Info-Santé et les soins palliatifs à domicile," *Première Ligne* Vol. XXII (1): 42–45.

Major, Francine A. et al., (2001) "Nursing Knowledge in a Mostly French-Speaking Canadian Province: From Past to Present," *Nursing Science Quarterly – Theory, Research and Practice* Vol. 14 (4): 355–359.

Programme Cadre Provincial de Formation Info-Santé; Projet pilote, (18 mai, 2006) Module 1: Communication et relation d'aide dans le cadre de mise en réseau du service Info-Santé ; Module 2: Démarche systématique: Méthodologie du traitement des appels; Plan de Formation; Ateliers.

RM. 1996. "Hospitals closing; prognosis: confusing." *Stanstead Journal,* January 24, 17.

Supporting Self-Care: The Contribution of Nurses and Physicians, (1997) Appendix B Selected Programs and Tools – The Info-Santé Service. Health Canada Website http://www.hc-sc.gc.ca/hcs-sss/pubs/hhrhs/1997-self-auto-contribut/info-eng.php retrieved August 10, 2008.

Wilson, Kathleen, Michael Jerrett and John Eyles, (2001) "Testing Relationships Among Determinants of Health, Health Policy, and Self-Assessed Health Status in Quebec," *International Journal of Health Services* 31(1): 67–89.