CHRISTINE FRANK AND ASSOCIATES

RESEARCH & EVALUATION

Health Quality Ontario
Learning Community Program Implementation Evaluation
Final Report

Quality Improvement
& Innovation Partnership
Advancing Improvement in Primary Healthcare in Ontario

Ontario
Health Quality Ontario

HQO -- Health Quality Ontario

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Executive Summary

Introduction

In April 2010, the Quality Improvement and Innovation Partnership (QIIP) began to develop a Learning Community program to promote quality improvement (QI) in family health teams and other primary healthcare organizations. The Learning Community consists of three main elements: 1) active periods to test and implement changes, 2) a virtual workspace called the Gateway for accessing tools and resources and sharing knowledge, and 3) quality improvement coaching.

To date, The Learning Community has been rolled out in two waves: Wave 1, beginning in September 2010, focused on QI in six different clinical areas, including five related to management of specific chronic diseases and one related to office practice redesign (OPR). Wave 2, beginning in February 2011, focused exclusively on OPR. 129 teams participated in Wave 1, and 71 in Wave 2.

The evaluation was intended to assess the implementation of the first two Waves of the Learning Community, with an eye to improving the components, learning what supports QI teams need, and informing the planning for Wave 3. Data were collected through a review of QIIP records, two surveys of team leads (actively participating and withdrawn), key informant interviews, and focus groups with team leads and the QI coaches.

In April, 2011, QIIP became part of Health Quality Ontario (HQO) as part of the consolidation of healthcare quality organizations in Ontario.

Summary of Lessons Learned and Suggestions For the Future

Development of the Learning Community

The development of the Learning Community was an intense iterative and collaborative effort. While bringing the Learning Community into being was exciting and rewarding for staff, it was also stressful. The rapid development also meant that one important element of the program, a database for reporting outcome measures, was not ready during the active periods for both Wave 1 and Wave 2. (See Implementation of the Learning Community Within QIIP/HQO and its Partners, p7; Suggestions about Expansion and Sustainability, p22; Technology Factors Affecting Full Participation, p20)

- In planning future Waves or future initiatives, lengthen the development time so that the planning can be less rushed and more deliberate. This will also enable clearer communication and better definition of roles.

- As The Learning Community matures and QIIP integrates with HQO, make efforts to maintain the collaborative approach and learning culture of The Learning Community, which is rewarding to staff and contributes to innovation. (See: Suggestions about Expansion and Sustainability, p22).

Recruiting Teams

Teams were attracted to the program because of their own past experience with QI (i.e., they had seen the positive impact firsthand) or because they had heard great things about it from other organizations. Some teams had specific improvement goals and thought the Learning Community could help them. External pressures (e.g., Ministry demands) were also a factor. (See: What Attracted Teams to the Learning Community, p14)

- Continue to encourage current participants who are experiencing success to talk about the benefits of their QI efforts, through their informal networks, presentations at conferences, articles, etc. (See: Suggestions about Expansion and Sustainability, p22).

Team Preparedness

In order to be successful in the Learning Community, coaches and managers felt that teams need to be motivated, committed, and have the ability (time, technical skills, etc.) to carry out the required activities, including reporting their measures. This was not always the case. Some of the teams, particularly those in Wave 2, did not feel fully "ready" to launch right into the Learning Community. For example, many in Wave 2 did not complete their preparatory work, and those with a limited understanding of QI concepts and terminology struggled in the first learning session. Readiness does have an impact on participation: in Wave 1, teams who withdrew from the Learning Community had lower readiness scores than those who remained active. (See: Characteristics of the Participating Organizations, p6; Reasons for Attrition, p17; Preparatory Work, p10; Team Characteristics / Readiness, p19)

- Readiness assessments might be used to identify teams that would benefit from a different type of intervention (if they are not yet ready for the Learning Community).

- Teams without previous QI experience may benefit from an extended and/or enriched preparation phase so that they can be ready for the first active periods. This preparation phase might include tutorials that introduce QI concepts and terminology, coaching to ensure that the team can extract relevant data from the EMR, an orientation to the Gateway, and having coaches walk the team through a sample active period so they can see how it works.

Elements of the Learning Community

The active periods were highly valued by the participating teams. Seeing positive results through their active periods is particularly motivating for team members and encourages them to try additional changes. (See: QI Culture, p12; Experiences with Various Elements of Learning Community, p14; Active Periods, p16)

Another very important element of the program was the coaching. The team leads very much appreciated the coaches' support and felt they encouraged active participation. (See: Experiences with Various Elements of Learning Community, 14; Coaching, p15; Program Factors Affecting Full Participation-Coaching, p18)

The learning sessions were also well received. The team members particularly appreciate opportunities to learn from each other, particularly when they meet face-to-face at the learning sessions. The face-to-face contact is effective in establishing relationships, building trust, and sharing ideas. (See: Experiences with Various Elements of Learning Community, p 14; Program Factors Affecting Full Participation-Learning Sessions p18)

Participants were less satisfied with the Gateway, and this component was generally underutilized. Levels of comfort with/interest in this type of technology vary among the teams. Few teams are reporting their measures on a monthly basis, in part because the data are difficult to extract from their systems (or are not being collected), and in part because the temporary reporting function has been difficult to use. (See: Using the Gateway / Reporting Data, p11; Experiences with Various Elements of Learning Community-The Gateway, p16; Technology Factors Affecting Full Participation, p20)

- Maintain the coaching, learning sessions, and active periods in future Waves.
- To the extent that resources permit, the learning sessions should be face-to-face. If virtual sessions are needed, better technology is needed.
- Learning sessions should include speakers who have applied QI before, and who can share their stories and successes. (See: Suggestions about Expansion and Sustainability, p22)
- The Gateway may need further development to be useful/desirable to participants. Soliciting user input will be important in informing this development. Learning Community staff may also want to research what has worked well in other online learning communities. Teams may also need a more in-depth orientation to the Gateway so that they understand how to reap maximum benefit from it.
- More support is needed to help teams extract and use data from their electronic medical records (EMRs). There may be a role for the Learning Community in supporting the teams (e.g., through coaching, connecting teams with similar types of EMRs, sharing any known software solutions) as well as in influencing what happens with EMRs at a provincial level. (See: Suggestions about Expansion and Sustainability, p22)
- It may be desirable to lengthen the entire program, to ensure that the teams have time to achieve gains even if they are delayed in getting started.

Broader Expansion of the Program

This evaluation did not capture data from enough participants in smaller practices that we can be confident in our understanding of their specific needs. However, the evaluation findings suggest that smaller practices may face unique challenges when participating in an intensive program like the Learning Community. For example, without relief staff, it is difficult for team members to attend the learning sessions or devote time to planning and implementing the active periods. It is reasonable to assume that technology issues (systems, internet, software, technical skills, and people's desire to use technology) might also be more problematic in smaller settings because of limited resources and the

smaller number of staff to draw on. (See Reasons for Attrition, p17; Team Characteristics / Readiness, p19; Suggestions about Expansion and Sustainability, p22)

- Further research is needed to better understand the needs of smaller practices. Other organizations such as the Ontario Medical Association and the Ontario College of Family Physicians may be able to help promote QI to these practices and help the Learning Community team understand these practices. (See: Suggestions about Expansion and Sustainability, p22)

- The Learning Community model may need to be adapted for solo practitioners and other very small practices to make it easier to participate (e.g., 20-minute webinars or coaching sessions, more structured program, brief virtual learning sessions, using huddles instead of team meetings, meeting outside of office hours, emphasizing easy wins that pay off quickly). Again, further research is needed to test this hypothesis.

Introduction

This report describes the findings of an evaluation of the implementation of the first two Waves of the Learning Community delivered by the Quality Improvement and Innovation Partnership (QIIP).

In April, 2011, QIIP became part of Health Quality Ontario (HQO) as part of the consolidation of healthcare quality organizations in Ontario.

Background

In April 2011, six organizations and programs were consolidated into Health Quality Ontario (HQO), an independent agency which oversees health care improvement work in Ontario. This consolidation moved the work of the Quality Improvement and Innovation Partnership (QIIP) into HQO. QIIP was originally formed to help Family Heath Teams in Ontario recruit staff and build teams, implement programs, develop links with community partners, introduce improvements into their practice, and establish structures to support these new directions. HQO (and formerly QIIP) is committed to supporting continuous quality improvement in the service of better population health, better provider and patient experience, and appropriate use of resources.

Strategic Objectives for Primary Healthcare Quality Improvement within HQO:

1. Advance quality improvement in primary healthcare by integrating, sustaining and spreading quality improvement methods.
2. Utilize performance measures to evaluate the quality improvement application and impact in primary healthcare.
3. Lead the creation, management and dissemination of knowledge.
4. Build organizational excellence through the development of key competencies and best practices.
5. Lead the development of partnerships and enhance relationships with key stakeholders in the healthcare system.

Learning Community

Beginning May 2008 to May 2010, QIIP initially implemented a series of three Learning Collaboratives based on the Institute for Healthcare Improvement Breakthrough Series. The method includes 3 two-day learning sessions, a congress, and active periods. Building on this initiative, QIIP designed and launched a province-wide Learning Community which consists of three main elements:

1. Active periods: based on the model for improvement and Plan-Do-Study-Act (PDSA) cycles for testing and implementing changes to practice.
2. Virtual Workspace (the “Gateway”): a web-based portal that is a real-time workspace for interaction and accessing tools and resources, as well as a secure space for reporting progress measures.

3. Quality Improvement Coaches: 17 regionally based coaches who build capacity within the participating organizations by supporting the integration and application of QI methodology.

To date, The Learning Community has been rolled out in two waves: Wave 1 focused on QI in six different clinical areas, including five related to management of specific chronic diseases and one related to office practice redesign (OPR), which focuses on improving office efficiency and patient access. Wave 2 focused exclusively on OPR.

Wave 1

Wave1 comprises six Action Groups (AG), including five AGs related to management of specific chronic diseases (asthma; COPD; diabetes; colon, breast and cervical cancers; and hypertension), and one AG focussed on office practice redesign. Each Action Group is guided by a Charter which outlines background Aim Statements and Measures to guide quality improvement. Wave 1 is scheduled to last 15 months.

The pre-work phase commenced in summer, 2010. Teams received the Pre-Work Package and Resource Binder which outlines the team activities. Prior to the first Learning Session, teams were required to:

1. Form the QI team
2. Meet with QI coach, determine team roles and set a meeting schedule
3. Complete Readiness Assessment with QI Coach
4. Sign on to gateway
5. Report changes to the QI team
6. Review pre-Work Package and Resource Binder
7. Complete a Clinic Walkthrough
8. Complete an Electronic Medical Record (EMR) Assessment form
9. Develop a Story board demonstrating success stories or favourite tools
10. Register team members for the first learning session

The first Learning Session (LS-1) was conducted sequentially in four regions across Ontario in September 2010. LS-1 included a review of Quality Improvement Methodology, Action Group specific content and quality improvement application ideas. Some clinical content was provided at the LS-1 also by partners for the respective Action Groups (the Ontario Lung Association, the Heart and Stroke Foundation, and Cancer Care Ontario). LS-1 was followed by an active period, during which time teams use PDSA cycles to test and implement improvements.

The second Learning Session (LS-2) was conducted virtually on January 19, 2011.

As of March 6, 2011, there were a total of 129 teams actively participating in Wave 1. They consist of FHTs and CHCs with previous QI experience (participation in the initial Learning Collaboratives) and Nurse Practitioner- Led Clinics (NPLCs) without QI experience. LS-3 occurred on April 27th, 2011. During the active period, teams are expected to test, implement, sustain and possibly spread changes to their practice.

In addition to completing the Pre-Work, attending the Learning Sessions and using PDSA cycles during active periods, teams are expected to measure and report results monthly. These reports are intended to assess progress, accelerate learning, assess and focus improvement and refine changes.

Wave 2

Wave 2 has one area of focus: Office Practice Redesign (OPR). The Learning Model for Wave 2 has undergone additional modification resulting in a shortened timeframe and the elimination of the third learning session. The nine month timeframe for Wave 2 includes six months of implementation followed by three months of "Holding the Gains". The target audience for this wave was extended to teams without previous QI experience and to all models of primary healthcare within the province (Family Health Teams (FHT), Community Health Centres (CHC), Nurse Practitioner-Led Clinics (NPLC), and solo or group practices). The first Learning Session (LS-1) was held in early February, 2011 followed by an active period. The second Learning Session (LS-2) for Wave 2 is scheduled for early May, 2011. Wave 2 participants are expected to complete Pre-Work, attend Learning Sessions, use PDSAs and report results monthly. As of April 14, 2011, a total of 71 teams are actively participating in Wave 2.

QIIP Activities

QIIP has designed the implementation of the Learning Community to take place through the following activities:

- Identify, contact and market QI concept to target groups
- Assess and score teams for readiness
- Recruit, train and mentor QI coaches
- Create self-assessment and reflective learning processes and structures
- Implement QI coach performance appraisals
- Support sites
- Design and deliver learning Sessions
- Plan celebrations of team accomplishments
- Share documents, tools resources
- Maintain and monitor the Gateway

Evaluation Purpose, Scope and Methods

Purpose

The purpose of this formative evaluation is to improve the design and implementation of the Learning Community initiative. It will provide feedback to improve the first two waves of the Learning Community (which are in progress), and inform planning for Wave 3, which will begin in September.

Scope of the Evaluation

The evaluation will focus on the implementation of the Learning Community up until May, 2011. It will include the first two Waves of The Learning Community implementation. The outcomes or impact of the Learning Community will be the focus of a separate evaluation, and will not be covered in this evaluation.

Guiding Questions for the Evaluation

The following questions guided the evaluation. These questions are further defined in the data collection matrix in Appendix A.

1. What are the characteristics of the participating organizations?
2. How was the Learning Community implemented at the QIIP/HQO level?
3. How was the Learning Community implemented at the team level?
4. What is the cost of implementing the Learning Community?
5. What were participants' experiences with the various components of the Learning Community? Do these experiences vary by governance model?
6. What are the reasons for attrition?
7. What factors seem to be related to full participation / adoption of the QI methodology?
8. How can the Learning Community be improved, expanded and sustained?

Evaluation Methods

This evaluation makes use of data gathered through a review of Learning Community records, two surveys, key informant interviews, and focus groups. The data collection matrix in Appendix A indicates how each of the methods contribute to answering the evaluation questions.

Records review

HQO provided the researchers with spreadsheets that contained information about teams that are participating or that have withdrawn from The Learning Community, along with administrative documents and Learning Community financial information. In addition, HQO provided the researchers

with access to the Gateway. Information from the records relevant to the evaluation questions were summarized.

Surveys, Interviews & Focus Groups

Table 1 outlines the different types of data obtained from the groups involved in the Learning Community.

Table 1: Primary Data Collection Methods

Method	Group	# participants
Survey	Team leads – Wave 1	49 (72%)*
	Team leads – Wave 2	41 (50%)*
	Withdrawn team leads	18 (34%)*
Interviews	AG leads	7
	External partners	4
	Learning Community managers	6
	Learning Community staff	3
	Informal champions	3
	Wave 2 FHGs/FHOs	1
	Solo practitioners	0
Focus groups	Wave 2 CHCs/NPLCs	5
	Wave 1 FHTs	7
	Wave 2 FHTs	6
	Wave 1 CHCs	3
	QI Coaches	7**

*parentheses indicate % of total population who responded to the surveys

** One of these coaches provided input in writing.

Limitations

QI Team Leads (currently participating)

Because of the moderate response rate (50%), the Wave 2 survey results may not be representative of all teams that participated in that Wave. In addition, due to their large numbers, FHTs influence the survey responses more than other groups. The percentage of team leads that responded to the survey varies by team characteristics. In particular, there was a poor response rate from FHOs (29%), FHGs (40%), and solo practitioners (40%).

QI Team Leads (no longer participating)

Only 18 of the 53 (34%) those invited responded to the survey. Because of the low response rate, we cannot treat the data as being representative of all teams that withdrew from the Learning Community.

Summary of Findings

This section integrates information from all of the data sources to answer the evaluation questions. Findings from QIIP records and the two surveys have been identified as such. Where it is not otherwise specified, the findings have come from interviews and focus groups.

Characteristics of the Participating Organizations

As shown in *Table 2* below, Wave 1 and Wave 2 of the Learning Community targeted quite different types of organizations. Participating Wave 1 organizations were predominantly FHTs[1] (and some CHCs) who had previously participated in QIIP's Learning Collaborative initiative. These organizations were therefore familiar with the general model used, and already had experience with QI.

Table 2: Characteristics of Participating Organizations

Characteristics of Participating Organizations	Wave 1	Wave 2
From Learning Community Records	**N=112**	**N=110**
Organizational Model	87% FHTs 13% CHCS	50% FHTs 10% CHCs 25% FHOs 15% Other
Average # teams participating	1.9	1.6
% with more than one QI team participating	37%	20%
From Evaluation Survey	**N=48**	**N=42**
Average # healthcare workers	21 Range: 3-60	13 Range: 1-70
Average size of patient panel (per team)	1,881 Range: 13-14,000	3,080 Range: 50-20,000
% who had participated in Learning Collaborative	91%	10%
% who rated their organization as "Very Good" or "Excellent" on the following dimensions:		
Readiness for the Learning Community	64%	41%
Physician engagement	52%	51%
Quality of collaboration on the team	66%	55%
Leader support for QI	86%	69%
Influence of QI champions	54%	43%
% who rated their organization as "Very Good" or "Excellent" in *at least one* of the following: physician engagement, leader support, or influence of QI champions	83%	74%

[1] For descriptions of each of these organizational models, please see the glossary in Appendix C.

In Wave 2, the Learning Community began to target organizations with different organizational structures and who had not participated in the Learning Collaborative. While over half of the participating organizations were FHTs and CHCs, Wave 2 also included a substantial number of FHOs, and also a handful of FHGs, NPLCs, FHNs, group practices, and solo practitioners. On average, the Wave 2 organizations had fewer healthcare workers than Wave 1 organizations, but larger patient panels.

Through the survey, team leads rated their organizations on a number of dimensions that may affect readiness for a QI effort, such as physician engagement, team collaboration, leadership support, and influence of champions for QI. As shown in *Table 2* , the Wave 1 organizations were generally stronger on these dimensions than the Wave 2 organizations. Findings from the focus groups were similar, with leads of Wave 1 teams indicating that they were very well prepared for the Learning Community, both in terms of QI culture and having systems already set up. Teams that were new to QI indicated they hadn't anticipated how much work would be required. "*If enthusiasm is a measure, we were extremely ready. Looking back on it now, and based on what was required of us, we didn't have the data put together."*

Implementation of the Learning Community Within QIIP/HQO and its Partners

The QIIP team set out to develop a more cost-effective model than the initial Learning Collaborative, with more virtual networking and support. The Learning Community's technological platform, the Gateway, enables participation by a larger number of teams and by more people within those teams.

Process and Capacity

Managers and Action Group Leads described a multi-step "iterative process'' as they developed the Learning Community, learning as they went along. There was excitement in being part of this pioneering effort, and they liked the collaborative style of the team. "*Everyone wanted this to work, and to be successful. Everyone was working for the good of the organization and of the product we were trying to deliver.*" Lack of role definition and communication from managers received some criticism, but these issues were understood to be the result of the iterative process.

To develop and implement the Learning Community, QIIP staff (with the help of their partners and a small number of external advisors and consultants, and building on the materials and processes from the Learning Collaborative,) hired and trained the QI coaches, developed recruitment materials, recruited teams to participate in the Learning Community, developed charters for the Action Groups, developed various resources to support the teams, developed agendas and materials for the learning sessions, developed performance measures and reporting templates, coordinated the development of the Gateway and a database for reporting measures, ran the learning sessions, provided QI coaching, held regular Action Group meetings, moderated the Gateway discussions, prepared aggregate reports of the monthly measures. A partial list of outputs produced for the Learning Community can be found in Appendix D.

A recurring theme was the amount of energy and focus that was required to mount the program in a short time period. "*This was like a 3 year adrenaline burst*." Respondents generally agreed that QIIP had

the capacity in terms of the skills, but that there was tremendous time pressure, leading to high stress and an unworkable build-up of lieu time. *"It certainly was not sustainable; we could not do it again."*

Leadership

Generally, respondents had a positive view of the QIIP leadership. "*The leadership for QIIP has been excellent. They were visionaries, brilliant when it came to looking down the road and forging the path. They could see things that needed to be developed*." Interviewees admired how much was accomplished and how everyone worked together. *"The leadership within QIIP was quite distributed. There were a lot of people engaged in providing leadership to different aspects of the program, including the administrative staff, the coaches, and the managers. That was why we were able to be as successful as we were in the short time frame."*

Roles

Managers were very hands-on, doing an array of tasks such as selecting and working with the Gateway developer, working with external partners to develop material, and hiring and involving the coaches. Alongside the managers, Learning Community staff members were key to handling logistics for learning sessions, communications (including formatting of documents), and helping to develop the Gateway.

Action Group Leads described a flurry of activity for both Wave 1 and Wave 2. Tasks included discussion with the QI director and partners, creating the charters (for Wave 1) and updating them (for Wave 2), planning for and setting up the Gateway, developing QI foundations curriculum, and developing the virtual coaching training program (not used due to the amalgamation). In some cases, measures were revised for Wave 2. Additional tasks included planning learning sessions and keeping their colleagues informed about the development and implementation of their Action Groups. The AG leads managed their portion of the Gateway, plus they had teams to coach.

The Learning Community coordinator oversaw all of the groups in Wave 1 and kept track of the larger trends that needed consideration. *"It is better to have one person doing this than to have the role rotate amongst AG Leads. Also, the coordinator is someone who can take care of all the little things that might otherwise fall through the cracks."*

Coaches worked directly with teams using the Readiness Tool, setting up meetings with teams, attending meetings, and answering questions. Some coaches helped teams with inputting measures into the Gateway after seeing that some of the teams couldn't get started. Coaches all reported being very busy, but the workload was greater for some.

Hiring and Training of Coaches

Some coaches came from the learning collaborative, and new ones were also hired, almost doubling the team. An HR consultant was retained to assist in hiring the coaches, and that process led to a good pool of applicants.

According to the documents, training for coaches included learning sessions about how to use the Gateway and about the aims, objectives and measures for the Action Groups. Coaches also participated in a three-day training session about effective coaching, and were given the option of participating in a formal mentorship program. New coaches participated in a four-week orientation with a more experienced "buddy." The training of the coaches was a challenge because of all the other work going on. Despite the challenges, coaches were pleased with their training. *"I think training went really well. Especially the fact we had a buddy that we could go to, we could ask questions, meet with them, discuss the basics of the job and what to expect. There was a training plan, a checklist that was really helpful."* The coaches did, however, feel overloaded at times.

External Partners

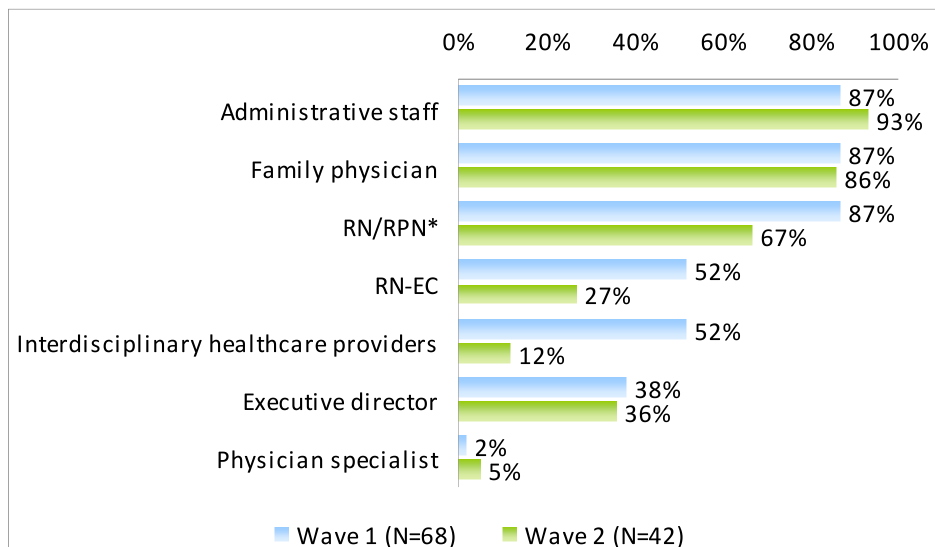
External partners (i.e., the Ontario Lung Association, the Heart and Stroke Foundation, and Cancer Care Ontario) reported being very involved with implementation, chiefly as clinical content experts. They helped develop the charters, developed learning materials and attended learning sessions. They feel their roles are essential and want to continue. In general, they believe that the Learning Community goals fit well with their own organizations' goals, stating that they too have a QI orientation.

Implementation Within the Participating Organizations

QI Teams

The QI teams within the participating organizations typically have about 5 members, though some have as few as 2 and others as many as 20. As shown in *Figure 1,* most teams include a family physician, an RN/RPN/RN-EC, and an administrative staff member. There were some differences in team composition between Wave 1 and Wave 2, which appear to reflect the different structures and sizes of the participating organizations.

Figure 1: Composition of QI teams, by Wave



Team leads reported that team members were carefully selected, sometimes including people resistant to change to encourage their "buy-in." Team leads said attitudes were generally positive toward the initiative, although some leads had to convince people to get involved.

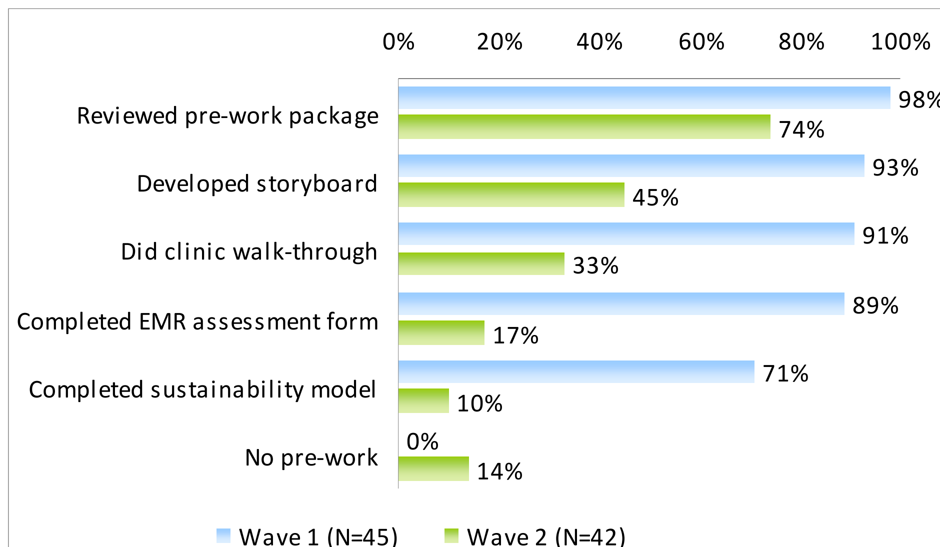
In the survey, most team leads reported that their teams met weekly (35%) or twice per week (33%). Only 10% of the teams met less than once per month. Some teams relied on "huddles" to discuss their plans and progress.

Preparatory Work

Almost all of the Wave 1 team leads who responded to the survey indicated that their team had done many of the preparatory activities for the Learning Community (see *Figure 2*). In contrast, Wave 2 teams were much less likely to report doing the preparatory activities. Approximately 14% of Wave 2 team leads reported that their teams did not do *any* preparatory activities. This result makes sense in light of interview comments about the shortened timeframe in Wave 2. "*What happened in Wave 2, is teams came together they still were figuring things out, but the clock had already started.*"

Wave 1 FHT focus group participants agreed that the first implementation step was updating and "cleaning" patient rosters, often a slow process. In some cases, teams went to great efforts to make changes, including coming in early and staying late to reduce backlogs. Wave 2 FHT focus group participants talked about taking time to understand the demands of the practice and track patient calls.

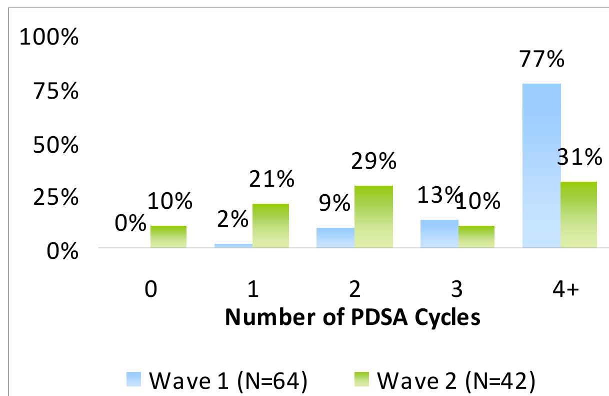
Figure 2: Completion of pre-work, by Wave



Active Periods

The survey results show that most of the teams had completed four or more PDSA cycles, with Wave 1 teams having completed more cycles than Wave 2 teams (see *Figure 3*), which is to be expected since Wave 1 has been operating for 8 months, compared to 3 months for Wave 2. Action Group leads and coaches reported that some teams are better than others at documenting PDSAs.

Figure 3: Number of PDSA cycles completed, by Wave



Coaching

Most of the teams (58%) communicated with their coach at least every 2 weeks. Wave 2 teams reported having more frequent contact with their coach than Wave 1 teams. Almost all of the teams (93%) communicated with their coaches by email. Many teams also spoke with their coaches in person (64%) or by phone (60%). Only 15% used new electronic tools to communicate with their coaches (e.g., Skype, web conferencing, or instant messaging).

Using the Gateway / Reporting Data

There was considerable variation in the extent to which the teams used the Gateway. Some (9%) team leads indicated that they read the Gateway discussions several times a week, while many (35%) read them less than once per month. Few (11%) survey respondents indicated that they posted to the Gateway on a regular basis.

Most (72%) of the survey respondents from both Waves indicated they were posting their measures on a monthly basis. This does not correspond with actual posting rates; according to Learning Community records, only 57% of active Wave 1 teams had posted their measures at least five times in eight months, and only 35% of active Wave 2 teams had posted measures at least twice in three months. Several active teams had not posted measures at all (13% from Wave 1, and 34% from Wave 2).

Role of Informal Champions

Informal Champions interviewed were lead physicians who took an active role in implementing and guiding QI initiatives at the team level. *"My main role was to take it and give it the go ahead, to make sure we stayed on track."* Some described how they garnered the support of upper management through their enthusiasm. *"As well, I've involved our medical director and executive director in this. I'm always blabbing about this."* These champions spread enthusiasm beyond their organizations by posting to the Gateway, presenting at Learning Sessions, developing workshops and making video presentations which are used on the QIIP website.

QI Culture

Leads reported that their teams had embraced QI culture, often quite enthusiastically. Once they begin to see results - for instance, patients' being able to get same day appointments - they are very keen to assess where other changes are needed and to try them out. Successful teams give all members plenty of input into the change process. "*Our evidence of a culture shift is when we started to have team members producing change initiatives and running with them. We are getting our colleagues' buy-in and are trying to measure changes. There is a true culture change for us."*

Enthusiasm, along with policies, directives, and staff education, was the key to spreading the culture to other areas. For CHCs, spreading can pose more challenges, given the diversity of their services. Putting infrastructure in place to support QI work can help.

Cost of the Learning Community

Costs to QIIP/HQO

The resources required to develop and launch the first two Waves of the Learning Community included:

- QIIP staff (three senior staff, a coordinator for Wave 1, three administrative staff, and regional coaches);
- Development of the website, the Gateway, and web-based reporting tool;
- Development of curriculum resources and tools; and
- Costs associated with the learning sessions (e.g., travel, accommodations, venue, speakers).

In total, developing and implementing the Learning Community cost $3,578,305 in the 2010-2011 fiscal year (see *Table 3* for details). Some of the costs from this first year are associated with the development of technology, curriculum, and materials, and would not be recurrent. Some costs for the first two Waves extended beyond the fiscal year, and are not captured in these numbers.

Table 3: Year 1 Costs of Developing and Implementing The Learning Community

	April 2010 – March 2011	
Type of expense	**Approved budget**	**Actual expenditure**
Human resources		
Salaries and benefits: • Coaches • Senior staff (weighted at 60%) • Administrative staff	$2,967,290	$2,340,476
External consultants and advisors (e.g., external physician and QI advisors; consultants who helped with EMR, curriculum development, logic model)	$200,000	$161,303
Coaching expenses, training and conferences	$462,650	$367,132

	April 2010 – March 2011	
Type of expense	**Approved budget**	**Actual expenditure**
IT Infrastructure		
Learning Community website / Gateway*	$50,000	$24,054
Web-based reporting tool and database	$60,000	$109,814
Learning Community curriculum / resource / tools / video development		
Wave 1	$94,800	$58,880
Wave 2	$130,000	$113,000
ICES data	$50,000	$15,000
Learning sessions (travel, venue, speakers)		
Wave 1	$225,000	$247,673
Wave 2	$150,000	$140,972
Total	**$4,389,740**	**$3,578,305**

*The Gateway also incurred additional development expenses of $20,000 in 2009-10.

In addition to the costs to QIIP, the external partners provided substantial in-kind contributions of their time and expertise.

Costs to the Participating Organizations

According to the team leads surveyed, the typical QI team spends about 8 hours per month on Learning Community activities, but the time spent does vary across teams (from as low as 1 hour per month to as high as 150 hours per month – see *Table 3* for average and median figures).

Table 4: Costs to Participating Organizations

	Wave 1	Wave 2
Time spent		
Average # hours	19 hours	9 hours
Median # hours	8 hours	8 hours
Expenditures		
% organizations incurring extra expenses due to participation in Learning Community	30%	5%
Of teams with expenses:		
Average expense	$12,367	$24,364
Median expense	$4,700	$24,364

One fifth of the participating teams (mainly in Wave 1) have incurred additional expenses related to the Learning Community, such as hiring additional staff, paying for relief staff, obtaining additional IT support, and purchasing new software (see *Table 3*). Across all survey respondents, the total amount spent was $111,300 for Wave 1 teams and $48,727 for Wave 2 teams.

Participants' Experiences with the Learning Community

What Attracted Teams to the Learning Community

For many teams, a positive experience in the Learning Collaborative led to a desire to continue the work. "*We joined because we learned so much in the first wave [learning collaborative], it really has changed our whole office concept.*" Some wanted to spread the improvements to other sites in their organization. In the background, demands from the Ministry for reporting and increasing panel size fed motivation. Some Family Health Teams in Wave 2 had heard about successes in other organizations. Some had started QI initiatives on their own and felt QIIP could help them. Others cited the need for improved morale or team building in their offices. Finally, some simply said they wanted to improve patient care and access, and they saw QIIP as the way to do it.

Overall Satisfaction with the Learning Community

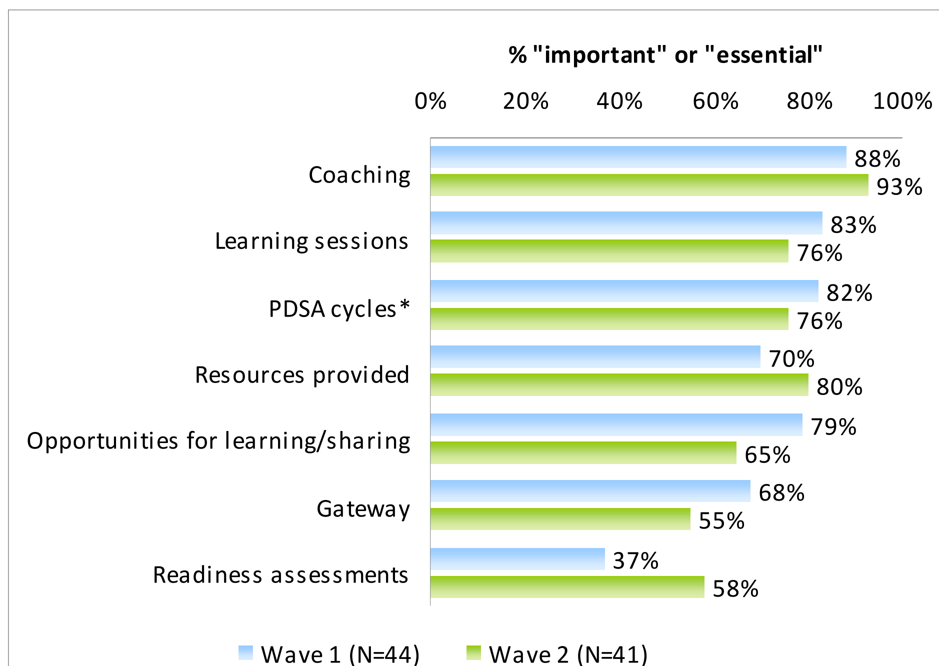
According to the survey, the teams were generally satisfied with their Learning Community experiences. The majority (79%) of the team leads surveyed indicated they received just the right amount of support provided by the Learning Community (6% felt they received too much support, and 15% not enough).

Experiences with Various Elements of Learning Community

Survey respondents were also asked to rate the usefulness of various aspects of the Learning Community to their QI initiatives. The findings from this question provide insight into which elements of the Learning Community are most important in supporting the teams. As shown in *Figure 4*, the coaching was seen to be critical by teams in both waves. Other elements that were particularly important include the PDSA cycles, the resources provided, the learning sessions, and the opportunities for learning and sharing.

It is interesting to note the difference in patterns between the Waves. It is possible that the usefulness of the different elements of the Learning Community might vary based on the team's QI experience or its organizational structure.

Figure 4: Perceived usefulness of different elements of the Learning Community, by Wave



**A different scale was used for this item; the number reported is the percentage of team leads who indicated that PDSA cycles "helped with quality improvement"*

The participants discussed several of these elements in the focus groups and interviews. The main themes that emerged are described in the subsections below.

Outreach

Among the team leads who responded to the survey, 83% indicated that they were satisfied with the accuracy of the outreach materials.

Coaching

The coaches are generally very well regarded. "*I have nothing but positive things to say about our coach. She has been on site, quick to respond by email; she helped us modify forms to fit our culture and the way we practice." "My coach has been here, and is wonderful."*

Coaches' site visits were very important to the teams. *"The coach is vital for keeping motivated. We would not have done it without a coach."* Over half of the survey respondents indicated their team could not have been successful without a coach. Teams often needed help handling data, and the coaches helped them through this process. *"The coach is instrumental. We don't know what to do with the data. The coach shows us the opportunities."*

Coaches themselves view their role as significant in the program, encouraging participation and answering questions. Both coaches and team leads recognize the coaches' active involvement decreases as teams become comfortable with the QI work. *"For mature teams, if they've got it they've got it, and they just need [the coach] very occasionally."* Some coaches reflected on the nature of their role, wondering if they should take more of a leading role to move teams forward. Still others felt they may

have been overly involved, resulting in teams not taking responsibility for their work. "*The only reason this team is meeting is because of [the coach].*"

Active Periods

Team leads and informal champions appreciated the PDSA model. *"We really enjoyed it as a process and appreciated all the learning involved. We did two process mapping sessions with the team and that led to a lot of improvements; also, the reception staff was able to streamline processes. It was a very good experience for the staff."*

Survey respondents indicated that the active periods helped to structure and organize their change efforts. They noted that the PDSA model made it easier to gain staff buy-in, because the team could start with small changes that seemed more manageable. This approach also enabled them to test the changes to see if they worked and/or were sustainable before fully implementing them.

The Gateway

Action Group leads and QIIP/HQO staff see the Gateway as an important tool, but one that is underutilized. "*Gateway could disappear and they wouldn't know it was gone.*" Coaches and Action Group Leads liked the ability to communicate with teams without having face-to-face contact and they also pointed out some particular features: searchability, downloaded meetings, and the quality café. They would like to see more participation (e.g., teams "*sharing their wisdom with the group*" on the Gateway by reporting data and posting to the discussion board), and wonder if teams could be more accountable for doing so.

Most (80%) of the team leads surveyed were satisfied with the accessibility of the Gateway, but fewer (65%) were satisfied with its ease of use. Some team leads found it difficult to navigate, and some were not aware that there was a search function. Evaluation participants gave various suggestions on how the Gateway could be improved, which are detailed in Appendix B.

Learning Sessions and Opportunities for Networking

These sessions were very popular with the teams, especially for the networking: "*the breakout sessions, they were monumentally helpful to us. I had interaction, meeting someone at a meeting, you're happy to help other teams, where you put a name to a face, you feel like you've got a connection with that team."* Presentations showcasing successes were helpful. Expert presentations were also helpful: *"It wasn't the same old same old. They were interesting, good speakers that kept your attention while you were listening. They told you the why and then they worked into the how, but mostly you work out the how yourself."*

Teams greatly appreciated the opportunity to connect, both virtually and in Learning Sessions, with others going through the same process. *"The last learning session, which was in Toronto, with everyone together, was a resounding success. Teams appreciated networking and coming together. This provided the richest experience."* Action Group leads and external partners also appreciated working together and learning from each other.

Many felt the smaller regional learning sessions were not ideal because there were very few participants in some of the Action Groups. The virtual learning session was complicated by the technological

demands inherent in the virtual format (e.g., several participants had trouble hearing the audio), and received lower satisfaction ratings from participants than did the face-to-face sessions. In spite of this, 31% of the team leads surveyed said that they would prefer virtual learning sessions (12% said they would not be interested in virtual sessions at all, and 57% said they would consider virtual sessions, but prefer face-to-face).

Virtual Methods of Support

Opinions varied regarding virtual methods of support, but stakeholders agreed that the technology and skills to connect virtually must be in place for virtual methods of support to be effective. Teams located in the far north of the province tend to be more savvy users of virtual methods, and expressed a preference for this method. However, only 16% of the team leads surveyed preferred virtual methods. Most recognise that virtual methods reduce travel time and costs, but at the same time many coaches and team leads prefer face to face meetings. "*I think interaction face to face has taken us far further than we could have done virtually".* Recognising the advantages of virtual and in-person support, some coaches and team leads recommend using both. "*It would be nice to have more user friendly virtual world to work through, and have a blended approach. I agree that the meetings with the coach are a definite motivator."*

Reasons for Attrition

Most often, coaches said the main reason for attrition was the amount of work required to participate in the program. "*Teams that have dropped out realize they don't have the resources, the time or the people to dedicate to the work; they think it's too much work."* Some teams experience staff turnover, which makes continued participation difficult. Other teams simply lack the enthusiasm to participate. "*Sometimes when teams come in because one person thinks it's a good idea, there's a lack of leadership engagement."* Still other teams may quit the program if they fail to see improvement. *"If they don't see results, they drop off."*

The survey of team leads who withdrew from the program had a low response rate, but may still provide some insight. The most common reasons these team leads gave for withdrawing were:

- Not enough time (12 respondents)
- Lack of physician engagement (11)
- Difficulties extracting or using EMR data (Wave 1 only) (10)
- Felt like we could do it on our own (8)

The teams' initial readiness assessment scores may also help to understand the reasons for attrition. In Wave 1, teams who withdrew tended to have less capacity for using measures, be less open to coaching support, and have lower overall readiness scores (see Table 5). In Wave 2, teams with a balanced QI team were more likely to remain active than those with an incomplete team. However, numeric readiness scores were not available for many of the Wave 2 teams, so this finding should be interpreted cautiously.

Table 5: Average Readiness Scores for Active and Withdrawn Teams

Average Readiness Assessment Scores	Withdrawn	Active	Difference
Wave 1	**(N=32)**	**(N=140)**	
Rationale for participation	3.9	4.1	0.2
Organizational support	3.8	4.0	0.2
Awareness of system care processes	3.4	3.7	0.3
Staff/team composition	3.6	4.0	0.4
Capacity for using measures / data extraction	3.4	4.1	0.7*
Previous QI experience / change management	3.4	3.7	0.3
Openness to external coaching support	4.2	4.6	0.4*
Overall readiness score	25.6	28.2	2.6*
Wave 2	**(N=7)**	**(N=52)**	
Rationale for participation	3.1	4.1	1.0
Organizational support	3.6	4.2	0.6
Awareness of system care processes	3.0	3.6	0.6
Staff/team composition	2.2	3.6	1.4*
Capacity for using measures / data extraction	2.6	3.3	0.7
Previous QI experience / change management	2.0	3.1	1.1
Openness to external coaching support	4.0	4.3	0.3
Overall readiness score	20.8	26.7	5.9

*Statistically significant difference using Analysis of Variance, $p<.01$

Factors Affecting Teams' Participation Once in the Learning Community

Program Factors Affecting Full Participation

Coaching

Coaches encouraged participation and helped teams through obstacles they encountered. Many team leads, Action Group leads, and coaches agreed that it would be difficult for most new teams to do QI work without a coach. Thorough readiness screening and initial training would be necessary for teams to be successful without coaching.

Learning Sessions

All stakeholders agreed that Learning Sessions are an important component of the Learning Community. Coaches and team leads recognise the value of networking in face-to-face sessions, and garner a sense of "energy" from these meetings. "*I think we need to have Learning Sessions that motivate and engage [the teams]. That seems to be their booster shot.*".

Program Philosophy
QI Coaches and Action Group Leads agreed that the program's non-judgemental philosophy intends to encourage participation, but the uptake of that approach may be challenging. "*There's a tension between the data piece and the non-judgmental for improvement message. People tend to think of data being used for judgment.*" Coaches reported continually encouraging teams to take small steps for change.

Active Periods
Team leads mentioned that coming to realise the value and function of PDSAs in their practice was an "aha" moment. "*It sounded like the most complex thing on earth. Now, we think this is a great PDSA, it's become an automatic part of our practice.*"

Timelines
Some Action Group leads and coaches said tight timelines negatively impacted teams' ability to participate fully in the program. "*I think the timelines were really tight, it takes the team a while to figure out how to do queries.*" Some teams needed extra time to do their preparatory work, and as a result they had a much shorter time for the active periods than was originally intended. In addition, some team leads indicated that they would have liked more advance notice of the learning session dates so that they could better plan their participation. "*Ideally in the future, my feedback is that those dates should be provided at outset of our participation.*"

Team Characteristics / Readiness

Commitment and Motivation
As indicated above, teams that remained active in the program had higher readiness scores than those that withdrew. This was statistically significant for Wave 1 (the numbers for Wave 2 were very low, making statistical comparisons problematic).

Coaches and managers noted that some teams were not ready to participate, and wondered if there could be a way to screen for readiness before acceptance into the Learning Community. "*Some teams are really not prepared to be part of this initiative. As a coach you feel like you're pulling teeth and it should not be that way. There should be some motivation on their part to meet the goals. If the readiness assessment could help with that or help us screen more, and not allow everybody in, it would be more useful that way.*" In order to be successful in the Learning Community, coaches and managers felt that teams need to be motivated, committed, and have the ability (time, technical skills, etc.) to carry out the required activities, including reporting their measures. For teams without these characteristics, they felt that other types of interventions would be more appropriate.

Knowledge
Several team leads also agreed that they were not fully ready for the program. Some team leads in Wave 2 noted they benefited less from the first learning session because they didn't yet understand QI concepts and terminology. "Right after first [learning session] it was like, 'Oh my gosh what are we to do?' By the second one, we better understood what was going on and the terminology."

Size of Practice

Participation was particularly challenging for small practices where relief staff are not available to fill in for team members and there are no dedicated resources for data management, QI support, etc. "T*here are very small teams, they don't have IT support*." Getting away for a full day learning session is particularly challenging in these settings. "*Wave 2 introduced a new dynamic, we are working with fee for service solo practice models, and they seem to be less receptive to closing the clinic and coming to the learning session."* Even finding time for planning or implementation of QI is difficult. There were few small practices participating in the evaluation (and in the learning community), so the data about the needs of these practices is somewhat limited. However, teams and coaches are adapting the program in different ways that appear to be successful. "*They don't have weekly QI meetings, they do huddles, because they don't have that dedicated time." "I'm probably helping them more with their data analysis / data collection part … that I wouldn't have to do with a team that had more capacity."* "*It's easier for me to pop in there, and everyone will come in an hour before the office opens."*

Technology Factors Affecting Full Participation

Technology factors merit a separate section because they can be a combination of organizational and external factors, plus they were very often cited as important factors.

Electronic Medical Record (EMR) Issues

Many teams face significant challenges extracting data from their Electronic Medical Record (EMR) system. Teams may have difficulty running queries to get at the data required for reporting purposes, or they may not have time to run the queries. *"Sometimes they can't get the data out of the EMR – either not functional, or no one has time."* An additional challenge is the large number of EMR systems in place in Ontario, which all operate differently. Most agreed that more support for EMR users would facilitate fully program participation. *"I think one of the main reasons [for teams not reporting measures] is lack of IT support to be able to pull those measures off."*

Data Reporting Function

Some survey respondents and interviewees noted that the (temporary) Excel-based data reporting function was difficult to use. A web-based reporting function was in development. (At the time of data collection, the web-based reporting function had not yet been completed; it has since been completed and launched.)

Technical Skills

Not all team members are equipped with the technical skills necessary to participate fully in the Learning Community. Some members are not familiar with Microsoft Excel, used for data reporting. "*"We assume everyone has access to a computer, knows how to use spreadsheets, stuff like that and it's not [the case]."* Others are not familiar with teleconference calls, when to take the microphone and talk, resulting in loss of interaction. *"Even though you've done the priming, asked individuals to speak, there's a lot of dead air space. You're waiting for people to come on and un-mute."*

Internet Access
Many of the Action Group leads reported that some teams cannot participate fully due to lack of internet access. Some teams have firewalls that prevent them from downloading from the Gateway. Still others may not have the necessary internet connection bandwidth to support online conferencing.

Compatible Software
Some teams faced challenges due to lack of compatible software, primarily between PC and Mac versions. "*One team is on Macs, not PCs, and the software for reporting is not compatible."*

External Factors Affecting Full Participation
Team leads cited reporting requirements for QIIP and subsequently for the government and other organizations as issues. For instance, different data or measures may be required, adding to the time and frustration of collecting and providing them."*I think something we've mentioned at our FHT, well the government wants these stats, why don't they send someone in to collect them? It's giving us better patient care, but it's the government that wants these; they should have a system where they are pulling that off instead of us spending time doing it."*

In some cases, teams have managed to compile data in the way required for QIIP and then discovered it was already being done by government. "*I agree in some cases for the cancer screening, it's collecting the exact same data, and it's frustrating to realise getting data, I've spent hours and hours pulling the data and I get a list from the ministry the exact same."*

Teams may also find the required statistics do not reveal the reality of their achievements. "*A lot of us have parallel users, the data we report is based on their guidelines, but it doesn't show the real life. When a patient needs something, they are able to have help the same day."*

Suggestions for Improvement, Expansion and Sustainability

Suggestions for Improvement
The study participants generated many suggestions for improvement to the program. Suggestions were typically made in the spirit of improving a program that worked well over all. Below is a summary of the most often mentioned areas for improvement. A full listing of suggestions, with example quotations, appears in Appendix B.

The Gateway was most often mentioned as an area for improvement, followed by learning sessions, timelines, communication, development of materials and measures, team readiness, active periods, and EMRs. Some of the most common suggestions for improvement include the following:

> Gateway: Improve user friendliness; employ more user input in development.
>
> Learning sessions: Improve learning session content (various suggestions); improve technology and limit group size for virtual sessions.

Timelines: Increase time for implementation and team pre-work; ensure adequate advance notice of dates requiring attendance.

Communication: Improve communication within QIIP/HQO; Clarify roles within QIIP/HQO; Improve communication with teams; Improve recruitment communication.

Team readiness: Apply minimum standards for acceptance into the program; Ensure teams are ready before beginning the program; Increase robustness of readiness tool.

Development of materials and measures: Allow stakeholder input and flexibility in QI measures; Improve pre-work materials; Set up a clear process and clear expectations for development of materials.

Active periods: Simplify the documentation required for PDSAs, or otherwise make it easier to do this documentation.

EMRs: Provide more support to teams to extract data from their EMR system

Suggestions about Expansion and Sustainability

As a new initiative, the Learning Community has reached only a fraction of the primary healthcare practices in Ontario. In expanding the program, The Learning Community will need to deal with the barriers to participation experienced by smaller practices, as well as encouraging their involvement. The following are some promising suggestions from evaluation participants for generating and sustaining interest in the program:

- Organizations like the Ontario Medical Association, Ontario College of Family Physicians might be able to assist by encouraging QI among their memberships. In addition, HQO can form deeper relationships with these organizations and with government to learn more about how to support solo practitioners.
- Success stories from other healthcare providers are a great motivator. Coaches can identify informal champions and support them in spreading the word about QI and inspiring people to take part. Informal champions are perceived to be more credible than formal champions.
- Ensure that practices have support in extracting and using data from their EMRs, because "you can't do it without an EMR."
- Show the teams how others have used their EMR data in the past to make improvements. "Don't make them re-invent the wheel." Provide tools for addressing some easy goals, and some that are harder.

Sustainability is also a consideration within the Learning Community team. As noted in the interviews, the pace of development for Wave 1 and Wave 2 cannot be sustained and will need to slow down.

In addition, as QIIP becomes part of HQO, it will need to adjust to the HQO culture and find its place within the larger organization. Learning Community managers feel it will be important to carry forward the collaborative approach and flat organization of QIIP, which has *"encouraged creativity and*

innovation and commitment." In addition, they feel that, to support QI work amongst primary healthcare workers, it is critical that the Learning Community team *"walk the talk"* by being a true learning organization that takes a QI approach to its own work.

Summary of Key Lessons and Suggestions for the Future

This section describes some key lessons from this evaluation, synthesizing findings from across evaluation questions, and highlighting the implications for Wave 3 of the Learning Community and for similar, future initiatives. References have been provided to the sections of the report that contain supporting data for each key lesson, as appropriate.

Development of the Learning Community

The development of the Learning Community was an intense iterative and collaborative effort. While bringing the Learning Community into being was exciting and rewarding for staff, it was also stressful. The rapid development also meant that one important element of the program, a database for reporting outcome measures, was not ready during the active periods for both Wave 1 and Wave 2. (See Implementation of the Learning Community Within QIIP/HQO and its Partners, p7; Suggestions about Expansion and Sustainability, p22; Technology Factors Affecting Full Participation, p20)

- In planning future Waves or future initiatives, lengthen the development time so that the planning can be less rushed and more deliberate. This will also enable clearer communication and better definition of roles.
- As The Learning Community matures and QIIP integrates with HQO, make efforts to maintain the collaborative approach and learning culture of The Learning Community, which is rewarding to staff and contributes to innovation. (See: Suggestions about Expansion and Sustainability, p22).

Recruiting Teams

Teams were attracted to the program because of their own past experience with QI (i.e., they had seen the positive impact firsthand) or because they had heard great things about it from other organizations. Some teams had specific improvement goals and thought the Learning Community could help them. External pressures (e.g., Ministry demands) were also a factor. (See: What Attracted Teams to the Learning Community, p14)

- Continue to encourage current participants who are experiencing success to talk about the benefits of their QI efforts, through their informal networks, presentations at conferences, articles, etc. (See: Suggestions about Expansion and Sustainability, p22).

Team Preparedness

In order to be successful in the Learning Community, coaches and managers felt that teams need to be motivated, committed, and have the ability (time, technical skills, etc.) to carry out the required activities, including reporting their measures. This was not always the case. Some of the teams, particularly those in Wave 2, did not feel fully “ready” to launch right into the Learning Community. For example, many in Wave 2 did not complete their preparatory work, and those with a limited understanding of QI concepts and terminology struggled in the first learning session. Readiness does have an impact on participation: in Wave 1, teams who withdrew from the Learning Community had lower readiness scores than those who remained active. (See: Characteristics of the Participating

Organizations, p6; Reasons for Attrition, p17; Preparatory Work, p10; Team Characteristics / Readiness, p19)

- Readiness assessments might be used to identify teams that would benefit from a different type of intervention (if they are not yet ready for the Learning Community).
- Teams without previous QI experience may benefit from an extended and/or enriched preparation phase so that they can be ready for the first active periods. This preparation phase might include tutorials that introduce QI concepts and terminology, coaching to ensure that the team can extract relevant data from the EMR, an orientation to the Gateway, and having coaches walk the team through a sample active period so they can see how it works.

Elements of the Learning Community

The active periods were highly valued by the participating teams. Seeing positive results through their active periods is particularly motivating for team members and encourages them to try additional changes. (See: QI Culture, p12; Experiences with Various Elements of Learning Community, p14; Active Periods, p16)

Another very important element of the program was the coaching. The team leads very much appreciated the coaches' support and felt they encouraged active participation. (See: Experiences with Various Elements of Learning Community, 14; Coaching, p15; Program Factors Affecting Full Participation-Coaching, p18)

The learning sessions were also well received. The team members particularly appreciate opportunities to learn from each other, particularly when they meet face-to-face at the learning sessions. The face-to-face contact is effective in establishing relationships, building trust, and sharing ideas. (See: Experiences with Various Elements of Learning Community, p 14; Program Factors Affecting Full Participation-Learning Sessions p18)

Participants were less satisfied with the Gateway, and this component was generally underutilized. Levels of comfort with/interest in this type of technology vary among the teams. Few teams are reporting their measures on a monthly basis, in part because the data are difficult to extract from their systems (or are not being collected), and in part because the temporary reporting function has been difficult to use. (See: Using the Gateway / Reporting Data, p11; Experiences with Various Elements of Learning Community-The Gateway, p16; Technology Factors Affecting Full Participation, p20)

- Maintain the coaching, learning sessions, and active periods in future Waves.
- To the extent that resources permit, the learning sessions should be face-to-face. If virtual sessions are needed, better technology is needed.
- Learning sessions should include speakers who have applied QI before, and who can share their stories and successes. (See: Suggestions about Expansion and Sustainability, p22)

- The Gateway may need further development to be useful/desirable to participants. Soliciting user input will be important in informing this development. Learning Community staff may also want to research what has worked well in other online learning communities. Teams may also need a more in-depth orientation to the Gateway so that they understand how to reap maximum benefit from it.

- More support is needed to help teams extract and use data from their electronic medical records (EMRs). There may be a role for the Learning Community in supporting the teams (e.g., through coaching, connecting teams with similar types of EMRs, sharing any known software solutions) as well as in influencing what happens with EMRs at a provincial level. (See: Suggestions about Expansion and Sustainability, p22)

- It may be desirable to lengthen the entire program, to ensure that the teams have time to achieve gains even if they are delayed in getting started.

Broader Expansion of the Program

This evaluation did not capture data from enough participants in smaller practices that we can be confident in our understanding of their specific needs. However, the evaluation findings suggest that smaller practices may face unique challenges when participating in an intensive program like the Learning Community. For example, without relief staff, it is difficult for team members to attend the learning sessions or devote time to planning and implementing the active periods. It is reasonable to assume that technology issues (systems, internet, software, technical skills, and people's desire to use technology) might also be more problematic in smaller settings because of limited resources and the smaller number of staff to draw on. (See Reasons for Attrition, p17; Team Characteristics / Readiness, p19; Suggestions about Expansion and Sustainability, p22)

- Further research is needed to better understand the needs of smaller practices. Other organizations such as the Ontario Medical Association and the Ontario College of Family Physicians may be able to help promote QI to these practices and help the Learning Community team understand these practices. (See: Suggestions about Expansion and Sustainability, p22)

- The Learning Community model may need to be adapted for solo practitioners and other very small practices to make it easier to participate (e.g., 20-minute webinars or coaching sessions, more structured program, brief virtual learning sessions, using huddles instead of team meetings, meeting outside of office hours, emphasizing easy wins that pay off quickly). Again, further research is needed to test this hypothesis.

Appendix A: Data Collection Framework

Evaluation Question	Dimensions of Interest	Data Source										
		Records review	Team lead survey	Attrition survey	QI coach action group lead interviews (9)	QIIP staff interviews (3)	QIIP manager & Wave 1 Coordinator interviews (6)	Informal Champion interviews (4)	Solo Practitioner Interviews (5)	External stakeholder interviews (3)	QI Coach focus group (1)	Team lead focus groups (5)
1. What are the characteristics of the participating organizations?	• Governance mode	✓										
	• # of health professionals in the practice		✓	✓								
	• # of QI teams	✓										
	• Reasons they became involved in the Learning Community								✓			✓
	• Previous experience with QI, including QIIP's Learning Collaborative		✓	✓					✓			✓
	• Quality of collaboration		✓									
2. What is the cost of implementing the Learning Community?	• QIIP/HQO expenditures • QIIP/HQO in-kind contributions	✓					✓					
	• Team expenditures • Team in-kind contributions		✓									
3. How was the Learning Community implemented at the QIIP/HQO level?	• Leadership / championing				✓	✓	✓			✓	✓	
	• Capacity to implement the Learning Community				✓	✓	✓			✓	✓	
	• Activities & Outputs For example: ○ Hiring and training of coaches ○ Development and distribution of materials ○ Learning sessions ○ Coaching ○ Gateway	✓			✓	✓	✓			✓	✓	
	• Timelines	✓			✓	✓	✓			✓		
	• Challenges / enablers				✓	✓	✓			✓	✓	

Evaluation Question	Dimensions of Interest	Data Source										
		Records review	Team lead survey	Attrition survey	QI coach action group lead interviews (9)	QIIP staff interviews (3)	QIIP manager & Wave 1 Coordinator interviews (6)	Informal Champion interviews (4)	Solo Practitioner Interviews (5)	External stakeholder interviews (3)	QI Coach focus group (1)	Team lead focus groups (5)
	• What was done differently than planned, and why	✓			✓	✓	✓			✓	✓	
	• Lessons learned	✓			✓	✓	✓			✓	✓	
4. How was the Learning Community implemented at the team level?	• Leadership / championing		✓					✓	✓			✓
	• Team characteristics o Size o Positions of those on the team o Position of the person in the team lead role o Level of involvement of physicians o Level of readiness to implement QI	✓	✓	✓					✓		✓	✓
	• Participation o Area(s) of focus o Completion of pre-work (walk-through, storyboard, assessments) o Frequency of team meetings o # learning sessions attended by the team o # goals set o # PDSA cycles completed o Frequency of reading or contributing to Gateway discussions o # of times posted progress assessments o # of times posted monthly reports o # of times posted data	✓	✓					✓	✓			✓
	• Degree and type of coaching received		✓									
	• How The Learning Community is implemented in solo practices, without allied health care workers		✓						✓		✓	✓
	• Challenges / enablers							✓	✓		✓	✓
	• What was done differently than planned, and why								✓		✓	✓
	• Lessons learned		✓					✓	✓		✓	✓
5. What were participants'	• Initial outreach and readiness assessment		✓		✓	✓	✓	✓	✓		✓	✓

Evaluation Question	Dimensions of Interest	Data Source										
		Records review	Team lead survey	Attrition survey	QI coach action group lead interviews (9)	QIIP staff interviews (3)	QIIP manager & Wave 1 Coordinator interviews (6)	Informal Champion interviews (4)	Solo Practitioner Interviews (5)	External stakeholder interviews (3)	QI Coach focus group (1)	Team lead focus groups (5)
experiences with the various components of the Learning Community? How can the components be improved? Do these experiences vary by governance model?	• PDSA cycles (number, format, length of cycles)		✓		✓	✓	✓	✓	✓		✓	✓
	• Action Group team calls		✓		✓	✓	✓	✓	✓			✓
	• QI coaches (incl. did they need one?)		✓		✓	✓	✓	✓	✓		✓	✓
	• Resources provided		✓		✓	✓	✓	✓	✓		✓	✓
	• Learning sessions (incl. amount of training)				✓	✓	✓	✓	✓		✓	✓
	• Degree of fit between level of support and needs of the team		✓	✓	✓	✓	✓	✓	✓		✓	✓
	• Provision of support (learning sessions, coaching) through virtual methods (including critical success factors, enablers, usefulness)		✓		✓	✓	✓	✓	✓		✓	✓
	• Gateway (including accessibility, ease of use, usefulness)		✓		✓	✓	✓	✓	✓		✓	✓
	• Reasons teams are not reporting their measures		✓		✓	✓		✓	✓		✓	✓
	• Opportunities for learning/sharing		✓	✓	✓	✓	✓	✓	✓		✓	✓
6. What are the reasons for attrition?				✓	✓	✓					✓	
7. What factors seem to be related to full participation / adoption of the QI methodology?	• Team characteristics (see #1)	✓	✓	✓	✓	✓		✓	✓		✓	✓
	• Components of the Learning Community (see #5)		✓		✓	✓		✓	✓		✓	✓
	• Elements of the underpinning philosophy: learn, share, innovate, improve				✓	✓		✓	✓		✓	✓
	• Participation in QI related to OPR, prior to clinical Action Groups				✓	✓		✓	✓			✓
	• Other factors				✓	✓		✓	✓		✓	✓

Appendix B: Detailed Suggestions for Improvement

The Gateway

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
Improve ease of use	*I just find a lot of people still have a hard time navigating through [the Gateway]. (QI Coach)* *I found it confusing to have to sort through things that people posted and things that QIIP posted. (Team Lead)* *I'm fairly technically savvy, and able to navigate and oftentimes I did have to communicate with the coach and say I can't find it, can you just email it to me. (Team Lead)* *[The Gateway] is not very user friendly. There is no easy way to input data we got. (Team Lead)* *I think there are too many steps. It does not work very well. It [uploading the data to the Gateway] is more work than it needs to be. (Team Lead)* *I find it too many clicks, to do things that should be just a link back. (AG Lead)*	4	•	•
Gather user input	*[Gateway] could be more user friendly, more user input in the design would be helpful. (QI Coach)* *We need to take [the Gateway] to the next level. What is*	3	•	

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
	missing right now is some input from the user. (Manager/Staff) *We may want to find out how to make it more user friendly by surveying and gathering feedback from the users. (Manager/Staff)*			
Utilize coaches to increase Gateway usage	*We can coach a team to contribute to the discussion board - it only is what the teams make it. (AG Lead)* *Directing people's attention to the gateway could be improved by the coaches. Rather than answering people's questions themselves, the coaches could be telling the teams to go to the gateway. (Manager/Staff)*	2		
Ensure website support in Wave 3	*As we move into wave 3 and we don't necessarily have an action group lead, we will need a dedicated resource for supporting that website. (Manager/Staff)*	1		
Offer Gateway training to new teams	*There needs to be more up-front communication about the gateway and its usefulness. So a learning session on the gateway might be value added. (Manager/Staff)*	1		

Learning Sessions

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
Reconsider learning session content	*I would have appreciated hearing from teams who had [similar] programs, versus the content or the knowledge, walking over the guidelines. (Team Lead)*	3		•

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
	At the COPD forum, we should have split the COPD and asthma groups. (External Partner)			
Ensure technology is in place for virtual learning sessions	*The virtual Learning Session was challenging. Not all teams had the technology to participate. Technology was challenging. (AG Lead)* *Our virtual Learning Session for Wave1 had a lot of logistical considerations that were not fine tuned and had less of an impact on teams. (AG Lead)*	3		
Limit group size in virtual learning sessions	*It was difficult to address all of the agendas in one session. The planning group was too large. (AG Lead)* *I think the mistake we made with the virtual learning session, we're had too many teams on the line than we should have had. (AG Lead)*	3		
Communicate learning session content in advance	*We need to identify and communicate in advance the attendance expectations to known sessions – what will happen, who will be speaking, what is the expectation of participating teams. (QI Coach)*		•	
Provide flexible dates for Learning Sessions	*There should be more flexibility for the in-person learning events. It would have been nice to have two dates [to choose from]. (Team Lead)*			•
Build on prior experience	*I also feel that the knowledge from previous efforts both internal and international is not harnessed in a way that dictates our steps forward. We seem to develop learning objectives from scratch for each Learning session or monthly*			•

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
	call versus following a methodical program outline. (QI Coach)			
Gather more stakeholder input	*Going back to the regional sessions, we would really need our stakeholders to give us input into what it is that stakeholders need. That whole thing about "designed with our stakeholders, for our stakeholders". We could do a lot better with that. (Manager/Staff)*	1		

Timelines

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
Allow more time for implementation	*Everything is done last minute, we end up working overtime and are stressed out. (Manager/Staff)* *Timelines were short sometimes in terms of pulling content and delivery together.(Manager/Staff)* *On timelines, we were overloaded with training opportunities, and that may have crowded out some of the other day to day tasks of coaching. (QI Coach)* *At times, it was really tight. That was the part that was most challenging in this process at the beginning I think there were external pressures to get going by a certain time…. I think it negatively impacted on the teams, it resulted in a lot of*	6	•	

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
	overtime, a lot of stress (AG Lead)			
Lengthen the pre work phase	*Timing felt pretty tight especially for teams that had no idea what they signed up for. (AG Lead)* *In W2, I was really concerned about the amount of pre-work time that teams had to prepare. Many have never done this before, there was virtually no pre-work time. (AG Lead)* *We need to have more lead time – the pre-work for teams needs to be extended so that when teams come to session 1, they are actually ready to start. (Manager/Staff)*	4		
Give teams more advance notice of important dates and timelines	*We work with teams and want to give them as much heads up as possible around dates but sometimes timelines are short. (QI Coach)* *We did not attend the last learning session. It was only 2 week's notice. It was too short of a notice. Ideally in the future, my feedback is that those dates should be provided at outset of our participation. (Team Lead)* *What was frustrating was the lack of timeliness, not being able to tell teams when things were going to happen until 10-15 days prior.(AG Lead)*	1	•	•

Communication

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
Improve communication within QIIP/HQO	*There's good leadership, I think, but it was crazy, crazy busy, so access to leaders was difficult, sometimes things weren't clear, we weren't able to understand the reasons for decisions. (AG Lead)* *There could be better communication for all the staff. (Manager/Staff)*	3		
Clarify roles within QIIP/HQO	*I was never clear about what level of support I was supposed to be giving to the Gateway. (AG Lead)* *I think nobody really knows what they are supposed to be doing, from the onset, and that is part of the problem why it is so disorganized. Nobody really knows their roles. You're just given jobs to do because they need to be done. (Manager/Staff)*	2		
Improve communication with teams	*I think there were perceptions around the cost of the Learning sessions too, around hosting at the Royal York; I know internally it was cheaper there than at flea bag hotel down the road, but we could have shared that with teams. (AG Lead)* *They maybe need more of agenda [for conference calls]. They try to send it out, but it more of what you are going to talk about, how it goes. They seem sort of wishy-washy. (Informal Champion)*	2		

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
Improve recruitment communication	*We really do need to get the outreach right. Where it didn't work well was when we gave the outreach communications to the OMA, that didn't work. (Manager/Staff)* *There was some challenges with recruitment… emails bouncing back, high staff turnover on the QI teams, so some members wouldn't get the messages.(Manager/Staff)*	2		

Team Readiness

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
Apply minimum standards for acceptance into the program	*We need a formal application process whereby teams need to express their ability and willingness to meet our expectations in writing. We evaluate the responses and grant approval to those who meet a minimum standard. (QI Coach)* *Even if we scored a team very low on the readiness assessment, there's not anything to say they are not ready to participate and we should tell them. It's like they have already been accepted, we're not turning anyone away. (QI Coach)*	2	•	
Ensure teams are ready before beginning the program	*Really the readiness assessment as a screening tool should be completed prior to the beginning of the wave. (QI Coach)* *The commitment required by the teams posed some*	2	•	

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
	challenges. Some teams were not aware of the commitment time needed. (Manager/Staff)			
Increase robustness of readiness tool	*Were there predictable things, if the readiness assessment was more robust, would we have been able to predict more? (QI Coach)*		•	

Materials (Development/Delivery/Measures)

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
Allow stakeholder input and flexibility in the measures	*One of the challenges is that the measures we use to demonstrate impact don't tell the whole story. When meeting with physicians or other team members, ask them if they have seen some non-measurable success for themselves. (Manager/Staff)* *I think the measures are too rigid, let each centre decide on their own measures, and even define their own measures, I think that would make QI more meaningful. (Team Lead)* *I would make sure [the users] were part of the ownership of the development. The timing precluded that in 2010. But what we learned very quickly in the fall of 2010 was that one of the charters … was totally wonky…. many of the physicians pushed back immediately on the charter measures being way too*	2		•

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
	strict, saying they did not reflect the complexity of patients in their practices. (Manager/Staff)			
Improve pre-work materials for teams	*I'm not sure if someone is doing an assessment of those pre-work materials, but I'm not sure we've hit it right just yet. (QI Coach)* *I would add that there was a disconnect between the pieces in W1, I think it's improved in W2. The disconnect was, "How does the pre-work relate to the Learning Session 1?" Sometimes you were developing a Learning Session without seeing what was in the pre-work. (AG Lead)*	1	•	
Set up a clear process and clear expectations for development of materials	*I would pass along a version [of a document], the next person would use a different version and change wording, it passed 3-4 people. Sometimes I was answering the same questions. Sometimes I wasn't sure how I contributed to it, if I wasn't explaining it. Sometimes I felt people weren't reading their email. A lot had to do with communication. … I think it would be good to have a discussion about how to develop those in the future and what the process is. (AG Lead)* *In the development of the package, [expectations] weren't clear enough, because the person I was working with had a very different view of view of what the package was for… We had difficult discussions around what was to be in or out. (AG Lead)*	2		

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	**Team Leads**
Supply printed copies of pre-work and charter materials	*Teams for wave 2 were emailed the condensed version of OPR, the charter and a bit of the pre-work but I agree [the materials] were lacking in terms of how comprehensive it was compared to Wave 1. By emailing it out, I found my teams don't look at their attachments. It was more work on my part. I would often bring it to the meeting and print it out to give it to them in person. (QI Coach)*		•	
Use consistent measures	*I think it was frustrating for teams that things changed so often, even we changed measures a couple of weeks ago. … Sometimes for teams they might have perceived that as being unorganized or unprepared. I feel a little funny being the messenger around those things. (AG Lead)*	1		
Develop comprehensive QI curriculum	*One would hope [the new QI curriculum] is more comprehensive and incremental in learning. (AG Lead)*	1		

Active Periods

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	**Team Leads**
Simplify PDSA documentation	*I wonder if there wasn't a way to simplify it to jot notes or something. I believe teams use the PDSA methodology in their heads, I believe they get the concept but its putting pen to paper that has not gone well. (AG Lead)*	3	•	

	It's torture... I think we make it more complicated than we need to.(AG Lead) *I don't think teams are good at documenting. I think the PDSA approach is fairly straight forward. I think by default teams do PDSAs, do test for change, they just don't write them down …they are just not strong on documenting outside of their clinical documentation process."(QI Coach)* *I think it's an easy concept to read about, it's a difficult concept for people to master. The whole writing it down has been a huge bug bear. (QI Coach)*			

EMR Support

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
Provide more support to teams to extract data from their EMR system	*That's really what our teams need – someone to guide with their EMR, and that's not built into our coaching strategy. (AG Lead)* *The electronic medical records (EMRs) are difficult. The big picture is that additional IT help is needed. (Informal Champion)* *We could better support teams about their EMR and their ability to track and measure data. (Manager/Staff)* *An area for improvement would be a more robust capacity to help teams with the use of their EMRs. (QI Coach)*	5	•	

Coordinate with EMR companies to ensure data measures can be extracted	*It is too hard for us to get our data…If you can't measure it, how are you going to improve it? … The data needs to be consistent and reliable. From the output side, we have to work on the EMR companies to do a better job at making the data accessible. (Informal Champion)*	1		

Resources

Suggestion	**Example Comments**	**# interviews where suggestion was made**	**Focus groups where suggestion was made**	
			QI Coaches	**Team Leads**
Supply funding/resources	*That is the only thing stopping us now from taking this across all our primary care programs. We need more capacity to collect the data and analyze it. (Informal Champion)* *It would be really helpful if the [program] came with additional funds. I don't have additional time to put towards it. (Team Lead)*	2		•

Suggestions from External Partners

Suggestion	**Example Comments**	**# interviews where suggestion was made**	**Focus groups where suggestion was made**	
			QI Coaches	**Team Leads**
Allow for more expert guidance along with the QI approach	*We need to combine the QI approach with providing guidance for clinical practice and evidence based resources such as diagnosis guidelines and patient information booklets.*	1		

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
	(External Partner) *I appreciate QI and have considerable experience with it but when teams are testing out small changes, that means that some of them are reinventing the wheel. Why not help them with something as frustrating as software issues? (External Partner)*			
Host more face to face meetings	*I think face to face meetings are really helpful and suggest more of them. "For instance, sometimes QIIP would send results in a document but a presentation, maybe with the Ministry present, would have more impact and create more recognition of the good work being done. Just written, it doesn't become alive and vibrant. We need to celebrate the successes* *and reflect on them together. (External partner)*	1		
Allow more partner input	*I think our position should have been stronger. For example, we need more of a local expert access aspect. We could provide regional specialists talks to help teams connect with a face in their community. (External Partner)*	1		
Provide more advance notice for meeting dates	*Since we need to attend the teleconferences if there are content issues to be discussed, we need to know ahead if that is the case and be consulted re our availability. (External Partner)*	1		
Gather stakeholder input	*Looking back, in developing the charter, not all stakeholders*	1		

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
on charter measures	*were brought together. There should be broader representation of organizations, physicians, and the community. (External Partner)*			

Miscellaneous Suggestions

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
Provide opportunities for similar organizations to network	*Moving forward it would be useful to have opportunities for our peers to come together, other CHCs, to come together in a face-to-face way. (Team Lead)*			•
Provide support in French	*It would have been great if we had a bilingual coach or French tools. (Team Lead)*			•
Provide new teams with starting point data	*Once you are accepted as part of the pilot, QIIP should present a picture of your organization based on Ministry data so everyone is starting from the same place. (Team Lead)*			•
Provide training to coaches on facilitation	*If I have a frustration around training of coaches, or competency, it's in the area of presentation and facilitation. I think that's one competency that we lack and an area we haven't focused any development on. (AG Lead)*	1		
Have senior team members work in the	*We need more of the senior team in the field with the QI teams. We have the coaches out there, but the senior team*	1		

Suggestion	Example Comments	# interviews where suggestion was made	Focus groups where suggestion was made	
			QI Coaches	Team Leads
field	*needs to be out there as well, to support the coaches and to send a loud message about our commitment. (Manager/Staff)*			
Develop local champions	*We need to develop local champions among physicians, so there is QI leadership by the sector, for the sector. (Manager/Staff)*	1		
Define roles for QI champions	*Utilizing QI champions [could be improved], we need to define that role. (Manager/Staff)*	1		
Improve coaching support	*There is opportunity [for improvement] for the day-to-day supports for coaches. They turn to me and they turn to each other, they have reflective practice triads that meet every month. But we could do better in that coaching support. (Manager/Staff)*	1		
Upgrade webinar software	*We need to get the best webinar software there is and then develop or hire expertise to manage/support this technology. (QI Coach)*	1		

Most Crucial Improvements

When asked a closing question: "what improvements would be most crucial?" respondents typically reiterated the above comments. Some introduced other suggestions not previously mentioned in the interview or focus group and those points are listed below in the table "Most Crucial (not mentioned above)." The table at the end of this section "Summary of Most Crucial Improvements" lists all suggestions made in response to the "most crucial" question.

Most Crucial (not mentioned above)

Suggestion	Example Comments	# interviews identifying this as most crucial	Focus groups identifying this as most crucial	
			QI Coaches	Team Leads
Increase awareness about the needs of different types of organizations	*I think there needs to be more awareness about the difference between FHTs and CHCs. (Team Lead)* *I agree the work of CHCs, particularly the complex folks we work with, I think there's some work to be done in that area. (Team Lead)* *I think it's to acknowledge the difference in the teams we're going to be working with in W3, than FHTs and CHCs. It's a whole other different world; we need to be really mindful of that when we design how we roll out wave 3. (AG Lead)*	1		•
Ensure measures are appropriate	*We need to be sure the indicators make sense for people using them. We did make some changes in response to feedback and we need to continue doing this. "It is OK with us if things have to be changed; there is always room for improvement." (External Partner)* *In terms of complexity, it would be more useful to have those measures broken down, maybe some index, to have it more customised. (Team Lead)* *There's disagreement as to what the science is saying, and why are we forced to conform to these indicators when some people feel they are not appropriate. So I'm not sure how much we can spread because there's disagreement among clinicians about what is appropriate testing. So I think there needs to be more discussion about indicators and what they are and why they are there. (Team Lead)*	1		•

Suggestion	Example Comments	# interviews identifying this as most crucial	Focus groups identifying this as most crucial	
			QI Coaches	Team Leads
Streamline the reporting process	*The reporting needs to be made easier. The data is there, but it is not being reported. (Team Lead)* *Streamline the [reporting] process. It would help us to use the site more efficiently (Team Lead)*			•
Provide more resources online	*Being face to face is great, but it is not always realistic. So more virtual opportunities would be value added. It can help bring people together who can't travel to Toronto. (Team Lead)* *I am in Toronto but didn't get to all the sessions. Having the ability to go back would be good. Having it taped and online would be good. Also, having the specific phone call sessions taped and online would be good for people to access later]. (Team Lead)*			•
Focus on OPR first	*The most important piece is to focus in on office efficiency and access. One of the challenges in W1 was that teams had the option to apply for a number of action groups, but if they do the OPR first, and gain the efficiencies, then they can free up time for prevention and promotion. Doing office efficiency, they can decide what they need to do. (AG Lead)*	1		
Build capacity in individuals	*The concept of us being capacity builders in individuals in organizations, rather than capacity builders in teams within organizations is crucial.(AG Lead)*	1		
Provide ongoing networking opportunities	*Networking is important. Better networking. It has been proven that they find creative ways to take time out of their business to attend the learning sessions for that networking. So, the learning sessions*	1		

Suggestion	Example Comments	# interviews identifying this as most crucial	Focus groups identifying this as most crucial	
			QI Coaches	Team Leads
	and staying connected between the learning sessions. (Manager/Staff)			
Develop QI culture	*I think [the most crucial improvement] is the culture issue. Whether we can continue to develop the kind of culture that is conducive to this work. (Manager/Staff)*	1		
Ensure meetings are productive and convenient	*Everywhere you go, people want you to be in meetings, and many are boring and useless. The more convenient it can be made, the better. The meetings should be not too long, and at times that work for people. Doing it at lunch or in the evenings is convenient.(Informal Champion)*	1		
Don't grow too fast	*I wish we could be clear about the model that we're using and what it takes to do it well and stick to that and not be thrown off course by pressure to get bigger when we don't have capacity. (AG Lead)*	1		
Make more use of the listserv	*I see a lot of merit to the listserv that comes straight to their inboxes. The fact that teams actually have to go to the gateway is limiting. There are a large number of people who don't go to these websites. (Manager/Staff)*	1		
Make participation easy with the right compensation and motivators	*If we want health care to change, then it's got to line up and make sense. The compensation and motivators have to make sense. Let's make the right choice the easy choice. (AG Lead)*	1		

Summary of Most Crucial Improvements

Suggestion	# interviews identifying this as most crucial	Focus groups identifying this as most crucial	
		QI Coaches	Team Leads
Ensure Team Readiness	6	●	
Make resources available to support QI work	2		●
Ensure measures are appropriate	1		●
Lengthen the pre-work phase	1		●
Provide EMR support	1		●
Increase awareness about the needs of different types of organizations	1		●
Allow more time for implementation	2		
Gather more stakeholder input	2		
Allow flexibility in the measures	1		●
Provide more resources online			●
Streamline the reporting process			●
Communicate learning session content in advance	1		
Focus on OPR first	1		
Build capacity in individuals	1		
Host more face to face meetings	1		
Improve communication within QIIP/HQO	1		
Offer Gateway training to new teams	1		
Provide ongoing networking opportunities	1		
Develop QI culture	1		
Ensure meetings are productive and convenient	1		
Don't grow too fast	1		
Make more use of the listserv	1		
Make participation easy with the right compensation and motivators	1		

Appendix C: Glossary of Ontario Primary Health Care Models

Credit: Brian Hutchison

Family Health Group (FHG)

An enhanced fee-for-service model offered to groups of three or more physicians to provide comprehensive primary care to their enrolled/assigned patients 24/7 through a combination of regular office hours, after-hours services and access to the Telephone Health Advisory Service (THAS).

Family Health Network (FHN)

A blended capitation payment model for groups of three or more physicians offering patients care 24/7 through a combination of regular physician office hours, after-hours services and access to a registered nurse toll-free through THAS.

Family Health Organization (FHO)

Similar to the FHN; however, including a different base rate payment associated with a larger basket of core services. No requirement to employ non-physician health care providers. FHOs are required to provide evening and weekend office hours and to provide on call backup to the ministry-funded after hours Telephone Health Advisory Service which is available to enrolled patients. "Group Leadership and Management Payment" based on the number of patients enrolled with FHO physicians. There is partial funding of a FHO administrator and paid a fee for enrolling unattached patients following hospital discharge and for enrolling new patients. Additional fees for preventive care outreach to enrolled patients (influenza vaccination of seniors, Pap smears, mammograms, immunization of children less than two years and colorectal cancer screening) and performance payments based on the proportion of eligible enrolled patients who receive these services.

Family Health Team (FHT)

A Family Health Team (FHT) brings together various interdisciplinary health-care providers to coordinate enhanced quality of care for the patient. FHTs consist of physicians working with other providers such as:

- Nurses, nurse practitioners

- Dietitians
- Mental health workers
- Social workers
- Pharmacists
- Educators and others
- Specialists

FHTs may choose from three governance structures:

- Community-led groups
- Provider-led groups
- Mix of provider groups and community groups

Family Practice

A family practice consists of the physical space and the people (health-care providers and staff) who provide family medicine/primary care services in one location. The interdisciplinary primary care professionals who work in a family practice include family physicians, nurse practitioners, family practice nurses, registered practical nurses, social workers, dietitians, pharmacists, specialists, educators and others. Staff members include receptionists, practice managers and administrative support.

Fee-For-Service

The method of billing for health services whereby a physician or other practitioner charges the Ontario Health Insurance Plan (OHIP) or the patient for each patient encounter or service rendered.

Community Health Centers (CHC)

A Community Health Center is community governed and globally funded by the Ministry of Health and Long Term Care. The Interdisciplinary teams of salaried primary care providers mainly serve socially disadvantaged and underserviced populations with a focus on primary healthcare, health promotion and community development.

Nurse Practitioner- Led Clinics (NPLC)

Staffing of NP-led clinics will include an administrator and at least one of the following: registered nurse, registered practical nurse, pharmacist, mental health worker, social worker and dietitian. Except for physicians, clinic staff will be remunerated through salary or sessional payments. Physicians will be compensated through a combination of fee-for-service for direct clinical care and a monthly stipend for consultation with NPs.

Appendix D: Selection of Learning Community Outputs

The following table lists a selection of Learning Community outputs that were reviewed in the course of this evaluation. It should be noted that this is not the complete list of outputs produced in the development and implementation of the Learning Community.

Output Name	Brief Description
Wave 1 – Learning Session 3 Draft Agenda April 27, 2011	A draft agenda of topics to be covered during Learning Community Wave 1, Learning Session 3 that took place on April 27, 2011.
Wave 1 – Learning Session 3 Evaluations PowerPoint	A PowerPoint presentation that shows how the participants rated Wave 1, Learning Session 3. Includes quantitative and qualitative data. The majority of participants agreed/strongly agreed that the session was useful.
Wave 1 – Learning Session 2 Final Agenda January 19, 2011	The agenda of topics to be covered during Learning Community Wave 1, Learning Session 2 that took place on January 19, 2011.
Sample Learning Session 2 Storyboard Template	A template that teams can use to disseminate their learnings to their peers.
The Planned, Prepared Visit Presentation – Tanya Spencer	A presentation showing the benefits of planning visits with patients to discuss health issues that aren't mentioned during acute care visits.
Planned, Prepared Visit – Mark Murray, January 19, 2011	A presentation that describes the benefits/logistics involved in planning visits with patients to discuss health issues that aren't mentioned during acute care visits.
Learning Session 1 Storyboard Template	A template that teams can use to disseminate their learnings to their peers. Also offers the goals and objectives of the storyboard sessions.
Wave 1 – Learning Session 3	An agenda of topics to be covered during Learning Community Wave 1, Learning Session 3 that took place on April 27, 2011.
Sample CRCS Process Map	A sample process map that teams can use as a guide when creating their own process maps.
Guelph FHT Dawson ICS Process Mapping November 2010 v2	Process map produced by the Guelph FHT to show their integrated cancer screening process for colorectal cancer.
QI Coach Learning Session Agenda June 10, 2010	An agenda for an event where QI coaches learned to link aims to measures, identify the aims, objectives and measures for Wave 1's action groups and disseminate relevant background information from each QI charter to teams.
Quality Improvement Coach Mentorship Program: Overview	This document produced/will produce a number of outputs, including: • Initial three hour introductory workshop for QICs • Mentorship workbook • One day orientation workshop for mentors and mentees to develop mentorship skills • Three month follow-up session

Output Name	Brief Description
	• QIIP website discussion group section for mentors and mentees • Evaluations of the mentorship program
Orientation for New QICs – Fall 2010 (4 week overview)	The orientation materials that were dispensed to three new QI coaches. This document includes all of the training and mentorship activities undertaken by the new coaches and their mentors throughout the four week orientation process.
Orientation Action Plan – Fall 2010	A checklist that outlines the various activities that had to be completed before the Fall 2010 orientation session for the new QI coaches.
On-line Learning Community Training	A document that describes the on-line learning community training process for all QIIP staff.
QI Coach Orientation – Agenda for New Coaches Nov 15th, Dec 1st and 2nd, 2010	Some orientation materials that were dispensed to three new QI coaches. This document includes all of the training and mentorship activities undertaken by the new coaches and their "buddies" throughout this three day orientation session.
Asthma Package of Change Concepts August 26, 2010	A package that describes the change concepts and ideas for innovation, that have been shown to improve the management of asthma in primary care practices. Once care providers have set their aim, they can use this package to choose priority areas of focus
Office Practice Redesign Package of Change Concepts February 14, 2011	A package that describes the change concepts for office practice redesign. These change concepts are best practices and tools/ideas that have been tested and demonstrated effectiveness in other environments that have moved towards and sustained advanced access.
Daily Demand Supply Activity Template 2010-2011	A tool that care providers can use to determine their daily demand, daily supply and daily supply used (activity) for the 2010-2011 year.
Wave 2, Learning Session 1 Make Up Session Evaluations– March 8, 2011	Displays participant feedback from Wave 2, Learning Session 1's make up session. Quantitative data has been graphed for each session and the overall conference. Participants also offered qualitative feedback about their experiences, which was generally positive.
Ideas Board – Office Practice Redesign Wave 2, Learning Session 2	The teams participating in this learning session each discussed what ideas and change concepts they have tested as well as how they have changed the way they work.
Wave 2 Monthly Measures for OPR Action Group	The progress being made by the OPR action groups in various measures is displayed in numerous graphs. For the most part, the aggregate scores for the groups are encouraging and show that they are making progress in achieving their goals.
LS1 Storyboards	Team storyboards from Wave 1, Learning Session 1 that are posted online. The storyboards describe the team's quality improvement journey and processes.
Office Practice Redesign Checklist for Advanced Access – March 1, 2011	A checklist tool that care providers can use to track their progress while transitioning to an advanced access appointment scheduling system.
Office Practice Redesign Charter – Wave 2 January 27, 2011	A document that describes the aims of office practice redesign during wave 2. The main aim is to improve primary care efficiency over a nine month period (six months of active learning followed by three months of sustaining those gains) by redesigning their scheduling system so patients

Output Name	Brief Description
	can see a care provider on the day of their choice.
Tools to Assist a Practice in Improving their Office Practice Redesign	A document that contains a number of tools (tracking forms and worksheets) that practices can use to track and improve their OPR.
Wave 2: Office Practice Redesign Getting Started Guide	A short guide that explains potential QI team roles, the role of the QI coach and some background reading that will be beneficial in making the transition to advanced access.
Wave 1 Participation March 6, 2011	A spreadsheet that displays both the amount and types of teams participating in the Wave 1 Action Group sessions that took place on January 5, 2011 and March 6, 2011.
Wave 2 Participation March 6, 2011	A spreadsheet that displays both the amount and types of teams participating in the Wave 2 Office Practice Redesign Session on March 6, 2011.
Wave 2, Office Practice Redesign Team Call 1 – April 1, 2011	A link to an MP3 file of a recording of Team Call 1 from Wave 2, OPR that took place on April 1, 2011.
Wave 2, Learning Session 2 Evaluations	Participant evaluations and feedback for Wave 2's Learning Session 2. Quantitative data has been graphed for each session and the overall conference. Some participant comments are also included in this document. Generally, the feedback was quite positive.
Stakeholder Advisory	An output informing stakeholders that Ontario's health quality infrastructure was consolidated. QIIP (Quality Improvement and Innovation Partnership), along with a number of other organizations were merged into Health Quality Ontario.
QI Foundations Evaluation February 1 and 2, 2011	Participant evaluations and feedback for the QI Foundations session that took place on February 1 and 2, 2011. Qualitative and quantitative data was gathered from participants on their views of the overall session. Most participants were satisfied with the session and had a better understanding of the Model for Improvement.
Learning Community Process Map for Coaches	A document that shows the timelines for activities related to the application and pre-work phases, learning session and active period phases as well as the congress and holding the gains phases of the quality improvement cycle.
Building Community Ties: Wave 1 Diabetes Action Group Webinar February 10, 2011	A webinar for the diabetes action group in which they were taught to build better ties with the local community. By the end of the webinar, participants should be able to locate the QIIP community partnerships resource guide, explain the role of community partners, identify the three levels of community engagement and identify quality improvement ideas related to community partners.
Asthma Action Group Tree Diagram June 18, 2010	A diagram for the asthma action group that shows the relationship between the overall initiative (improve asthma management in patients aged 2-55 over a 12 month period in a primary care setting), aims and change concepts.
Asthma Charter – Wave 1 July 5, 2010	A document that describes the aims of the asthma action group during wave 1. The main aim is to increase asthma management in primary care settings for patients aged 2 – 55 over a nine

Output Name	Brief Description
	month period by an increased use of spirometry and the development of asthma action plans with patients.
Contacts for Team Presenters from Learning Session 2	Contact information for two presenters from Learning Session 2.
Learning Community Wave 1 Data for Asthma December 2010	The progress being made by the Asthma action groups in achieving their targets in various measures. The action groups achieved their target in one area, but according to these aggregate scores, they do not seem to be making great progress towards achieving their goals in other areas that are being measured.
Improving Management of Asthma with Planned Prepared Visits	A graphic that shows the relationship between the overall goals of the asthma action group and how planned prepared visits will help achieve those aims in an efficient manner.
Diabetes Action Group Breakout Session September 2010	A presentation where participants learned to distinguish between process and outcome measures in terms of diabetes management, examples of a primary care system of diabetes management care and change concepts and personal learning goals that can improve diabetes care at their practices.
Improving Diabetes Management with Planned Prepared Visits	A graphic that shows the relationship between the overall goals of the diabetes action group and how planned prepared visits will help achieve those aims in an efficient manner.
New Vision FHT's Lung Health Program	The New Vision FHT shares the story of the growth of their lung health program as well as experiences and best practices from the quality improvement journey.
Office Practice Redesign Action Group Tree Diagram June 11, 2010	A diagram for the office practice redesign action group that shows the relationship between the overall initiative (reduced waiting times, improved clinical outcomes and increased patient and provider satisfaction by allowing patients to see their provider on the day of their choice), aims and change concepts.
Asthma Action Plan: Questions and Answers April 20, 2011	A poster that advertises a question and answer session that took place for teams that are part of the QIIP asthma learning communities. The session was designed to give the target audience baseline knowledge about the asthma action plan. Teams were also encouraged to complete their own Asthma action plan.
Office Practice Redesign Charter – Wave 1 June 29, 2010	A document that describes the aims of office practice redesign during wave 1. The main aim is to improve primary care efficiency over a nine month period (six months of active learning followed by three months of sustaining those gains) by redesigning their scheduling system so patients can see a care provider on the day of their choice.
Panel Size Equations with Scenarios v2	A document that shows the panel size equation used to obtain roster balance. Various scenarios and examples are offered (as well as the correct answers) so teams can practice using the equation before using it in their practice.
Office Practice Redesign Pre-Work Data Collection Sheet	A sheet that teams can use to record data prior to their enrolment in the learning community. This particular sheet applies exclusively to the office practice redesign group.

Output Name	Brief Description
Contents of OPR (Primer) Folder Posted to the *GATEWAY* Tools and Resources	A document that lists the various tools and resources posted on the Office Practice Redesign discussion group on GATEWAY.
Office Practice Redesign Glossary v3	A list of definitions for uncommon terms referred to throughout the office practice redesign learning sessions/knowledge documents.
Office Practice Redesign Action Group Team Call November 16, 2010	Slides that accompanied a webinar for teams participating in the office practice redesign action group. The goals of this presentation were to meat other members of the action group, share measures and challenges to date, as well as better understanding the relationship between supply and demand and variation.
Office Practice Redesign: Access and Efficiency September 14, 2010	This presentation is designed to teach acre providers about advanced access scheduling and the principles of access and efficiency. The principles are applied in an Ontario context and participants are taught to use equations to better understand their panel size and the demands on their practice.
Learning Community Wave 1 Data for Asthma – March 2011 April 18, 2011	The progress being made by the asthma action group members toward achieving their targets in various measures. The data is correct as of March 2011. Overall, the action group is having mixed results as far as achieving their targets.
Learning Community Wave 1 Data for COPD – March 2011 April 18, 2011	The progress being made by the COPD action group members toward achieving their targets in various measures. The data is correct as of March 2011. Overall, the action group is having mixed results as far as achieving their targets.
Learning Community Wave 1 Data for Hypertension – March 2011 April 18, 2011	The progress being made by the Hypertension action group members toward achieving their targets in various measures. The data is correct as of March 2011. The group seems to be making great progress at an aggregate level, although it looks like it has been difficult to hold the gains made in some areas.
Learning Community Wave 1 Data for Integrated Cancer Screening – March 2011 April 18, 2011	The progress being made by the ICS action group members toward achieving their targets in various measures. The data is correct as of March 2011. The group has been making great progress and has almost achieved their targets in every measure.
Learning Community Wave 1 Data for Diabetes Management – March 2011 April 18, 2011	The progress being made by the diabetes management action group members toward achieving their targets in various measures. The data is correct as of March 2011. Overall, the action group is having mixed results as far as achieving their targets.
Director, Quality Improvement – Position Description	A description of the role and key responsibilities for the Director of Quality Improvement position. The competencies, experience and education required to fill the position are also explained.
Manager, Quality Improvement Initiatives and Coaching – Position Description	A description of the role and key responsibilities for the Manager of Quality Improvement Initiatives and Coaching. The competencies, experience and education required to fill the position are also explained.

Output Name	Brief Description
Communications Coordinator – Position Description	A description of the role and key responsibilities for the Communications Coordinator position. The competencies, experience and education required to fill the position are also explained.
Quality Improvement Coach – Position Description	A description of the role and key responsibilities for the Quality Improvement Coach. The competencies, experience and education required to fill the position are also explained.
Quality Improvement Initiatives Coordinator – Position Description	A description of the role and key responsibilities for the Manager of Quality Improvement Initiatives and Coaching. The competencies, experience and education required to fill the position are also explained.
Notes from Weekly Check In – June 30, 2010	Notes from the June 30, 2010 learning community weekly staff check-in meeting.
Weekly Check In – Wednesday July 7, 2010	Notes from the July 7, 2010 learning community weekly staff check-in meeting.
Weekly Check In – Wednesday July 21, 2010	Notes from the July 21, 2010 learning community weekly staff check-in meeting.
Weekly Check In – Wednesday July 28, 2010	Notes from the July 28, 2010 learning community weekly staff check-in meeting.
Weekly Check In – Wednesday August 11, 2010	Notes from the August 11, 2010 learning community weekly staff check-in meeting.
Weekly Check In – Wednesday August 18, 2010	Notes from the August 18, 2010 learning community weekly staff check-in meeting.
Weekly Check In – Wednesday August 25, 2010	Notes from the August 25, 2010 learning community weekly staff check-in meeting.
Learning Community Weekly Check In – Wednesday September 1, 2010	Notes from the September 1, 2010 learning community weekly staff check-in meeting.
Learning Community Weekly Check In – Wednesday September 8, 2010	Notes from the September 8, 2010 learning community weekly staff check-in meeting.
Team Call Agenda and Notes – January 19, 2011	An agenda that lists the topics, questions and action items that were discussed by the QI team on January 19, 2011. Topics discussed include role clarity as well as planning and scheduling the make-up sessions for learning session 1 and wave 2, learning session 2. A separate document includes notes from this meeting.
Team Call Agenda – January 26, 2011	An agenda that lists the topics, questions and action items that were discussed by the QI team on January 26, 2011. Topics discussed include a review of the charter and measures, preparations for a primary health care overview presentation and updates on the work of the QI champion. A separate document includes notes from this meeting.
Team Call Agenda – February 16, 2011	An agenda that lists the topics, questions and action items that were discussed by the QI team on February 16, 2011. Topics discussed include gateway, a discussion of what QI coaches are hearing from the field, navigational webinars and reporting.
Team Call Agenda – February 23, 2011	An agenda that lists the topics, questions and action items that were discussed by the QI team on February 23, 2011. Topics discussed include logistics and preparations for the learning session one make up session and an update to the OPR workbook.
Team Call Agenda – March 2, 2011	An agenda that lists the topics, questions and action items that were discussed by the QI team on March 2, 2011. Topics discussed include logistics and preparations for the learning session

Output Name	Brief Description
	one make up session, access to QI champions and the learning needs and delivery method for learning session 2.
Roles and Processes	A document that identifies the various roles and responsibilities of various QIIP personnel/departments. The action group processes (as identified by the quality improvement coaches) have also been identified.
W2, LS1 Evaluation February – Spreadsheet	For the most part, the participants agreed/strongly agreed that the session was worthwhile, well organized and would help them improve their practice and clinical work. Some of the respondents did indicate that they would have liked more of an opportunity to interact with other teams.
W2, LS1 Evaluation March Make-Up Session – Spreadsheet	A list of comments made by those who participated in the Wave 2, Learning Session 1 Make Up Session. Many felt the session was helpful, but too long.
Learning Session Attendees	A table showing the number of attendees for each learning session by governance model. Wave 1 is dominated by FHT's as they represented approximately 80% of the attendees. The rest of the attendees for Wave 1 are CHC's. For Wave 2, the main pool of attendees are still FHT's, but CHC's, FHO's, solo practitioners and NPLC's are also represented.
Action Group Reporting – April 11, 2011	Progress reports and reporting data for all of the Wave 1 action groups are recorded in this table, along with any other pertinent information about each group. Most of the groups are reporting an average score in the 2.7 – 3.2 range, while the medians are in the 2.75 – 3.25 range.
Wave 1 Naming Convention Spreadsheet – June 14, 2011	A spreadsheet that details the names of each team and organizations, their QI coach and contact information for each team member. Teams that have withdrawn from QI are also listed, along with their reasons for leaving the program. The most common reason for withdrawal has to do with staffing/human resource concerns. The progress scores (mean and median) are also displayed in this document.

Appendix E: Data Collection Tools

QI Team Lead Survey

10-15 minutes

Survey Consent

This survey will ask about your experiences with the QIIP Learning Community. Your answers will help QIIP (now Health Quality Ontario) improve the Learning Community.

What you need to know:

- The survey takes 10-15 minutes.
- You can stop at any time and come back to it later.
- The survey is completely voluntary.
- As a thank-you for participating, your email address will be entered into a draw for a $100 Chapters gift card. The winner will be notified by June 10th.
- Your answers will be kept confidential. They will be maintained by Cathexis Consulting Inc. and will not be shared with Health Quality Ontario.
- We will report only aggregate (group) findings. We may also report the findings separately for different types of organizations (e.g., FHTs, FHNs, NPLCs, CHCs etc.) as long as there are at least five respondents in the group.

Do you agree to complete the survey, and for your answers to be used to improve the Learning Community?

- O Yes
- O No

Please answer this survey from your perspective as a QI team lead.

How many different Quality Improvement (QI) teams do you lead?

- O One Team
- O More than one team

The survey differs slightly depending on answer to above question. The language used is pluralized for leads with more than one team, and those leads are to complete certain team characteristics and activities information for each team.

About your QI Team

The following questions ask about your QI Team's composition and previous experiences.

1) Approximately how many patients are in the panel associated with your QI Team? ______ (Enter number)

2) How many people are part of your QI Team? ______ (Enter number)

3) Which of the following are part of your QI team? (Select all that apply)
   - ☐ Family Physician
   - ☐ Physician Specialist
   - ☐ RN / RPN
   - ☐ RN – EC
   - ☐ IHP – interdisciplinary healthcare providers
   - ☐ Executive Director
   - ☐ Administrative Staff
   - ☐ Other – describe

4) Before starting this wave of the Learning Community, did you or any member of your current QI team or healthcare team have previous experience with quality improvement, including QIIP's Learning Collaborative?
   - ○ Yes
   - ○ No
   - ○ Don't Know

About your Organization

The following questions ask about characteristics of your organization (e.g., your FHT, your practice, etc..

5) Approximately how many healthcare providers work in your practice? (e.g. physicians, NPs, nurses, AHPs etc.) ______

6) Did your organization participate in any of QIIP's Learning Collaboratives that took place in 2008 to 2010?
   - ○ Yes
   - ○ No
   - ○ Don't Know

7) We would like to better understand the importance of organizational factors in supporting QI initiatives. Please rate your organization on each of the following factors:

	Excellent	Very Good	Good	Fair	Poor	Not applicable
Your healthcare team's level of readiness to start the QI work and participate in the Learning Community?	○	○	○	○	○	○

The level of engagement of the physician(s) on your QI team	○	○	○	○	○	○
The quality of collaboration amongst the healthcare team	○	○	○	○	○	○
Leaders' support for QI within the organization	○	○	○	○	○	○
Existence and influence of champions for QI within the organization	○	○	○	○	○	○

8) Approximately how many hours per month is your team spending on Learning Community activities? ______ (Enter number, considering the time commitment across all members of the team)

9) Has your team faced any actual expenditures as a result of participating in the Learning Community including the need to hire or seek IT support?
   - ○ Yes
   - ○ No
   - ○ Don't Know

10) *If the responsent answers "Yes" to the previous question:* What type of expenditures has your team faced as a result of participating in the Learning Community? (Select all that apply).
   - ☐ Purchased new computer systems
   - ☐ Purchased new computer software
   - ☐ Hired addition staff. Please estimate the number of additional full-time equivalents____________
   - ☐ Other expenditures, please specify: __________________________

11) *If the respondent answered, "Yes" to question 9*: Please estimate the amount of actual expenditures faced by your team as a result of your participation in the Learning Community? $______ (enter number)

Your QI Team's Activities

The following questions ask about your QI Team's activities.

12) Please indicate which of the following pre-work activities your QI Team completed prior to the first Learning Session: (select all that apply)
   - ☐ Review the pre-work package
   - ☐ Do a Clinic Walkthrough
   - ☐ Complete the sustainability model
   - ☐ Complete the EMR assessment form
   - ☐ Develop a storyboard

- ☐ Other, describe: ____________________
- ☐ None of the above

13) How often do you hold QI Team meetings?
- O Daily
- O Several Times a Week
- O Weekly
- O Bi-Weekly
- O Monthly
- O Less Often

14) How often do you personally read Gateway discussions?
- O Several Times a Day
- O Daily
- O Several Times a Week
- O Weekly
- O Bi-Weekly
- O Monthly
- O Less Often

15) How often do you personally contribute to Gateway discussions?
- O Several Times a Day
- O Daily
- O Several Times a Week
- O Weekly
- O Bi-Weekly
- O Monthly
- O Less Often

16) How often do you communicate with your QI Coach?
- O Several Times a Day
- O Daily
- O Several Times a Week
- O Weekly
- O Bi-Weekly
- O Monthly
- O Less Often

17) What methods do actually use to communicate with your QI coach? (select all that apply)
- ☐ In person (face-to-face)
- ☐ Telephone

- ☐ E-mail
- ☐ Other electronic communication (e.g., instant messaging, Skype, web conferencing)
- ☐ Other – describe ________________________
- ☐ None

Your Perceptions of the Learning Community Program

The following questions ask about your perceptions of the Learning Community Program.

18) How satisfied are you with the Learning Community program, overall?	Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied
	○	○	○	○	○

19) How *useful* were the following Learning Community components to your team's QI initiative(s)?

	Essential	Important	Nice to Have	Not Necessary	N/A
The readiness assessments	○	○	○	○	○
The resources provided (e.g., pre-workshop package, QI charter, change concept package, progress assessment scales, PDSA templates, other resources posted on the Gateway)	○	○	○	○	○
Coaching from the QI coach	○	○	○	○	○
Gateway	○	○	○	○	○
Opportunities for Learning / Sharing	○	○	○	○	○
Learning Sessions	○	○	○	○	○
Other	○	○	○	○	○

If choose "Other," please specify:________________________

20) How satisfied were you with the following elements of the Learning Community:

	Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied	N/A
Accuracy of the initial outreach materials (i.e., the description of the program)	○	○	○	○	○	○
Weekly/bi-weekly action group team calls	○	○	○	○	○	○
Accessibility of the Gateway	○	○	○	○	○	○
Ease of use of the Gateway	○	○	○	○	○	○

Learning sessions	O	O	O	O	O	O
Coaching that you received	O	O	O	O	O	O

21) How many Plan-Do-Study-Act (PDSA) cycles has your team completed?
   - O 0
   - O 1
   - O 2
   - O 3
   - O More than 3

22) *If answered "0" to previous question:* What are the reasons your team has not yet completed a PDSA cycle?

23) Do you feel that PDSA cycles have helped with quality improvement?
   - O Yes
   - O No
   - O Maybe

   Please explain: _____________________

24) How do you feel about the amount of activity/discussion on the Gateway?
   - O There is not enough activity/discussion
   - O The amount of activity/discussion is about right
   - O There is too much activity/discussion
   - O My opinion varies depending on the Action Group – describe: __________________
   - O Don't know / not sure.

25) Do you believe your team could have successfully undertaken your QI activities without your QI coach?
   - O Yes, definitely
   - O Yes, but it would have been more difficult
   - O No, we couldn't have

   Please explain: _____________________

26) How would you rate the level of support the Learning Community program provided your team for QI?
   - O More support than we needed
   - O Just the right amount of support
   - O Not enough support

27) Did you attend any Learning Sessions using OTN (videoconference)?

- O Yes
- O No

28) Assuming the technology works effectively, would you be interested in attending virtual learning sessions (i.e., learning sessions held over the internet, instead of in person)?

- O Yes, that would be my preferred method
- O I would consider it, but would prefer to meet in person
- O No, I would not be interested in virtual learning sessions at all

29) What methods would you prefer to use when communicating with your QI coach? (select all that apply)

- ☐ In person (face-to-face)
- ☐ Telephone
- ☐ E-mail
- ☐ Other electronic communication (e.g., instant messaging, Skype, web conferencing)
- ☐ Other – describe ________________________

30) Are you currently posting your action group measures to Gateway on a monthly basis?

- O Yes
- O No

31) *If the respondent answered "No" to the previous question*: What are the reasons you aren't posting your action group measures on Gateway on a monthly basis? (Select all that apply)

- ☐ We aren't collecting the data
- ☐ We are collecting the data, but can't get it out of our EMR system
- ☐ We would prefer that our colleagues not see our data
- ☐ We are concerned that the Ministry might see our data
- ☐ The spreadsheet to post our data is problematic
- ☐ The mechanism to post our data is problematic
- ☐ Other, describe: _____________________________

32) Please list any suggestions you have for how to improve the QIIP program, including the coaching, the Gateway, and the PDSA cycles.

____

____

QI Team Leads Survey for Teams Who are No Longer Participating

Please answer this survey from your perspective as a QI team lead.

How many different Quality Improvement (QI) teams do you lead?

- ○ One Team
- ○ More than one team

The survey differs slightly depending on answer to above question. The language used is pluralized for leads with more than one team, and those leads are to complete certain team characteristics information for each team.

About your QI Team and Organization

The following questions ask about the composition and previous experiences of your Quality Improvement (QI) Team.

1) Approximately how many patients are in the panel associated with your QI Team? ______ (Enter number)

2) How many people were part of your QI Team? ______ (Enter number)

3) Which of the following were part of your QI team? (Select all that apply)
   - ☐ Family Physician
   - ☐ Physician Specialist
   - ☐ RN / RPN
   - ☐ RN – EC
   - ☐ IHP – interdisciplinary healthcare providers
   - ☐ Executive Director
   - ☐ Administrative Staff
   - ☐ Other – describe

4) Approximately how many healthcare providers work in your <u>practice</u>? (e.g. physicians, NPs, nurses, AHPs etc.)______________________

5) Before starting this wave of the Learning Community, did you or any member of your current QI team or healthcare team have previous experience with quality improvement, including QIIP's Learning Collaborative?
   - ○ Yes
   - ○ No
   - ○ Don't Know

Your Perceptions of the Learning Community Program

6) How would you rate the level of support the Learning Community program provided your team for QI?
   - ○ More support than we needed
   - ○ Just the right amount of support
   - ○ Not enough support

7) What are the reasons your QI team stopped participating in the Learning Community? (Select all that apply)
   - ☐ The purpose of the program was different than we had expected
   - ☐ It required too much time
   - ☐ Lack of physician engagement and participation
   - ☐ Lack of leadership
   - ☐ Difficulty extracting or using EMR data
   - ☐ We weren't ready to begin this type of quality improvement
   - ☐ Dissatisfaction with the Learning Community program
   - ☐ We felt like we could do QI on our own, without the program
   - ☐ We didn't want to report data outside our organization
   - ☐ Specialist/clinical expert
   - ☐ Other, describe: ______________________________

8) Is there anything else that you would like to tell us about your experiences with the Learning Community?

____

____

Interview Consent

(Common to all interview guides)

This interview will ask about your experiences with the QIIP Learning Community. Your answers will help QIIP (now Health Quality Ontario) improve the Learning Community.

What you need to know:

- The interview takes xx minutes.
- Participation is completely voluntary.
- The interview will be recorded with your consent. Recordings will be kept for six weeks, and then destroyed. The recordings are for note taking purposes only and will not be shared.
- Your answers will be kept confidential. They will be maintained by Christine Frank and Associates and will not be shared with Health Quality Ontario.

- In reporting the results of interviews, we will report only aggregate (group) information. However, we may attribute certain findings to certain groups (e.g., L-Comm staff, L-Comm managers, coaches, external partners, and opinion leaders). Because of the small number of individuals within each group, it is possible that readers may be able to identify your personal viewpoints.

Do you agree to participate in this interview, for the interview to be recorded, and for your answers to be used to improve the Learning Community?

Action Group Leads Interview Guide

(50 minutes)

We recognize that you will have two perspectives, one as a coach and one as an action group lead. In particular, we are interested in your perspective as an Action Group lead in planning and partnering with content experts and implementing Learning Sessions. We will be hearing from other coaches in a focus group.

1. Would you please describe your role in the Learning Community program? (3 min)

2. Please comment on the following aspects of the Learning Community program. What happened? What went well? What should be changed or improved? (20 min)

    a. Possible areas for comment
        i. QIIP's capacity to implement the program (e.g., resources, knowledge, staffing)
        ii. Leadership within QIIP/HQO for this program
        iii. Partnership with content experts
        iv. Timelines
        v. Hiring and training of coaches
        vi. Development of materials (e.g., charters, pre-work package)
        vii. Readiness assessment tools
        viii. Learning sessions
        ix. Coaching
        x. Gateway
        xi. PDSAs

3. This series of question asks for your thoughts or hypotheses on issues relating to difficulties teams may face. (10 min)

    a. Some teams are not reporting their measures. What do you think are the reasons for this?
    b. Some teams drop out along the way. What do you think the reasons are for this?
    c. What challenges do teams face in using the Gateway?
        i. Do you see a difference in the level of participation between Wave 1 and Wave 2 teams on the Gateway?

4. The next three questions ask for your perceptions on providing support for teams. (5 min)

    a. What do you feel is the ideal number of teams per coach?
    b. How do you feel about using virtual methods to provide support such as virtual learning sessions, virtual coaching? How useful is it? What is needed to make it work?
    c. Do you think some teams might be able to implement the program without a coach, and if so, how can we determine which ones?

5. The next three questions ask about the factors that influence full participation in the program. (10 min)

    a. How do you think the characteristics of the organization/teams affect participation in the program? (Prior experience in QI? Governance models? Team composition? Other?)
    b. How do you think the various program elements affect participation?
    c. How does the program's philosophy of non-judgmental sharing and expecting only small incremental steps affect participation? And upon reflection do you feel the program is truly progressing in that manner… "walking the talk?"

6. Of the possible improvements we have discussed over the course of this interview, what do you feel is most crucial? (2 min)

Learning Community Staff Interview Guide

(45 minutes)

We are interested in your views on the QIIP program from your perspective as key staff members.

1. Would you please describe your role in the QIIP program? (3 min)

2. What do you feel worked well about the program? What should be changed or improved? (15 min)

    a. Possible areas for comment
        i. QIIP's capacity to implement the program (e.g., resources, knowledge, staffing)
        ii. Leadership within QIIP/HQO for this program
        iii. Timelines
        iv. Development of materials (e.g., charters, prework package)
        v. Learning sessions
        vi. Recruitment and enrolment of teams
        vii. Tracking of team participation

3. How well do you feel the Gateway is working as a vehicle to communicate with teams? What could be changed or improved? (5 min)

4. This series of question asks for your thoughts or hypotheses on how the L Comm Program is supported. (15 min)

a. How well are QI Coaches supported? Are there areas where support for QI Coaches could be improved?
b. How do you feel about using virtual methods to provide support such as virtual learning sessions, virtual coaching? How useful is it? What is needed to make it work?
c. How well do you think other social media avenues (such as Twitter, Facebook) would support the roll out of the LC? How could these avenues be utilized?

5. Now that you have acquired new skills (Lean certification and Project Management skills) how would you incorporate these skills in supporting the current Waves and the roll out of Wave 3? (5 min)

6. Of the possible improvements we have discussed over the course of this interview, what do you feel is most crucial? (2 min)

Learning Community Managers Interview Guide

30 minutes

You are one of five Learning Community managers and directors invited to participate in an interview about the QIIP program implementation. These include the Director of the Quality Program, the Manager of the Quality Program, and two Senior Advisors.

1. Please describe your role in the QIIP program. (3 min)

2. Would you please describe the resources that were dedicated to the Learning Community, including both dedicated expenditures and in-kind resources? (4 min)

3. Please describe how the Learning Community program was developed and implemented at QIIP, using the following headings as a guide: Please describe the development and implementation of each, followed by what you thought worked well or areas for improvement. (15 min)

   a. QIIP's capacity to implement the program (e.g., resources, knowledge, staffing)
   b. Leadership within QIIP/HQO for this program
   c. Timelines
   d. Hiring and training of coaches
   e. Development of materials (e.g., charters, prework package)
   f. Learning sessions
   g. Coaching
   h. Gateway

4. Do you feel you have a culture in place now that will be able to sustain any gains made? (2 min)

5. Of the improvements we have talked about, what do you feel is most crucial to the success of the program? (2 min)

Learning Community Wave 1 Coordinator Interview Guide

30 minutes

You are one of five Learning Community managers and directors invited to participate in an interview about the QIIP program implementation. These include the Director of the Quality Program, the Manager of the Quality Program, and two Senior Advisors.

1. Please describe your role in the QIIP program. (3 min)

2. Please describe how the Learning Community program was developed and implemented at QIIP, using the following headings as a guide: Please describe the development and implementation of each, followed by what you thought worked well or areas for improvement. (15 min)

    a. QIIP's capacity to implement the program (e.g., resources, knowledge, staffing)
    b. Leadership within QIIP/HQO for this program
    c. Timelines
    d. Hiring and training of coaches
    e. Development of materials (e.g., charters, prework package)
    f. Learning sessions
    g. Coaching
    h. Gateway

3. How did the coordinator role contribute to the success of the Learning Community? If a future iteration of the Learning Community were to include multiple action groups, would you recommend that there be a coordinator? Why or why not? (5 min)

4. Of the improvements we have talked about, what do you feel is most crucial to the success of the program? (2 min)

External Partner Interview Guide

10 -15 minutes

We are interested in your views as a partner in the development and implementation of the QIIP program.

1. Please describe your role and your organization's role in the planning and roll-out of the Learning Community. (3 min)

2. How does the Learning Community program, as it has evolved, fit with your organization's goals? (3min)

3. Now I would like to hear your comments about the Learning Community process and also the resources in your Action Group Area. From your perspective, what do you feel worked well? What can be improved? (5 min)

4. Finally, of the improvements we have talked about, what do you feel is most crucial to the success of the program? (1 min)

5. Would you like to add anything? (1 min)

Informal Champions Interview Guide (30 minutes)

We understand you have embraced the quality improvement methodology and would like to hear your thoughts about the Learning Community Program.

1. Please describe your role in supporting the implementation of the Learning Community Program. (3 min)

2. What do you feel is working well about the program? (5 min)

    a. Possible areas for comment:

        i. Learning Sessions
        ii. Coaching
        iii. Gateway
        iv. PDSAs

3. What elements of the program could be changed or improved? (5 min)

    a. Of the improvements we have talked about, what do you feel is most crucial to the success of the program?

4. What factors have enabled you to be an informal champion of quality improvement in primary healthcare? (2 min)

5. In general, what supports to organizations/teams are necessary for successful adoption of QI methodology? (5 min)

6. How would you recommend QIIP/HQO spread the L-Comm program to other physicians/teams in Ontario? (5 min)

    a. What role do you think *formal* champions of QI might play in supporting the spread of the L-Comm program?

7. What do you think are the biggest barriers to the spread of quality improvement in primary health care? (3 min)

8. Would you like to add anything? (2 mins)

Solo Practitioner Interview Guide (30 minutes)

1. Would you please tell us a little about your team, and your role within your practice? (2 min)

2. What were your reasons for becoming involved in the L-Comm? (3 min)

3. How was L-Comm implemented within your organization? What steps did you take and who was involved? (5 min)

4. The next series of questions asks for thoughts on some specific aspects of the program. (10 min)

    a. How ready was your team/organization to participate in the L-Comm? Where there ways you could have been more ready?

    b. How does the leadership or championing of QI within your organization affect your participation?

    c. Was your team involved in previous QI programs? How does previous participation affect your participation in *this* program?

    d. Some teams are not reporting their measures. What do you think are the reasons for this?

5. What aspects of the program were most helpful? What aspects could you have done without? (e.g. thinking of the various components). What were your big 'aha' moments? (5 min)

6. Finally, in a few words, please tell us what would be the most important thing to do to improve the program. (3 min)

7. Do you have anything to add? (2 min)

Focus Group Consent

(Common to both focus group guides)

This focus group will ask about your experiences with the QIIP Learning Community. Your answers will help QIIP (now Health Quality Ontario) improve the Learning Community.

What you need to know:

- The focus group takes xx (90 minutes for QI Coaches, 60 minutes for team leads) minutes.
- Participation is completely voluntary.
- The focus group will be recorded with the consent of all members of the group. Recordings will be kept for six weeks, and then destroyed.
- Your answers will be kept confidential. They will be maintained by Christine Frank and Associates and will not be shared with Health Quality Ontario.
- We will report only aggregate (group) findings.

By introducing yourself, you are confirming your consent to participate in this interview, and for your answers to be used to improve the Learning Community.

Are there any objections to the interview being recorded? The recording will be used only to ensure that our notes are accurate.

QI Coach Focus Group Guide (90 Minutes)

1. We'll start with some introductions. Would you please tell us your name and a little about your role in the L-Comm program?

2. What do you feel worked well about the program? What should be changed or improved?
    a. Possible areas for comment
        i. QIIP's capacity to implement the program (e.g., resources, knowledge, staffing)
        ii. Leadership within QIIP/HQO for this program
        iii. Timelines
        iv. Hiring and training of coaches
        v. Development of materials (e.g., charters, prework package)
        vi. Readiness assessment tool
        vii. Learning sessions
        viii. Coaching
        ix. Gateway
        x. PDSAs

3. The next series of questions asks for thoughts on some specific aspects of the program.

    a. How do you feel about using virtual methods to provide support? (e.g., virtual learning sessions, virtual coaching), including how useful it is, and what is needed to make it work?

    b. Were all teams ready to participate in L-Comm? If not, how might it be possible to identify those teams in the future?

    c. Might some teams be able to implement the program without a coach? If so, how might it be possible to determine which teams?

    d. Based on your experiences so far, how are solo practitioners are implementing the L-Comm?

e. What do you feel is the ideal number of teams per coach? Is there an optimal number of teams that a coach can manage?

4. Thinking about challenges faced in the program so far, I have two questions:

    a. Some teams are not reporting their measures. What do you think are the reasons for this?

    b. Some teams drop out along the way. What do you think the reasons are for this?

5. The next three questions ask about the factors that influence full participation in the program.
    a. How do you think the characteristics of the organization/teams affect participation in the program? Prior experience in QI? Governance models? Team composition? Other?
    b. How do you think the various program elements affect participation? For instance, how important are the learning sessions? Are they important for all teams? Other program elements?
    c. How does the program's philosophy of non-judgmental sharing and expecting only small incremental steps affect participation? And upon reflection do you feel the program is truly progressing in that manner… "walking the talk?"

6. (If time permits) Of the possible improvements we have discussed over the course of this focus group, what do you feel is most crucial?

Team Lead Focus Group Guide (60 minutes)

1. We'll start with some introductions. Would you please tell us your name and a little about your team, and your role within your practice?

2. What were your reasons for becoming involved in the L-Comm?

3. We are interested in how L-Comm was implemented within your organization. As we have a lot to cover, I will ask one of you to describe the steps you took and the people involved. Then I will ask the group what major variations you might have experienced in your implementation.

4. The next series of questions asks for thoughts on some specific aspects of the program.

    a. How do you feel about using virtual methods to provide support? (e.g., virtual learning sessions, virtual coaching), including how useful it is, and what is needed to make it work?

    b. How ready was your team/organization to participate in the L-Comm? Where there ways you could have been more ready?

c. How does the leadership or championing of QI within your organization affect your participation?

d. Was your team involved in previous QI programs? How does previous participation affect your participation in *this* program?

e. Might some teams be able to implement the program without a coach? If so, how to determine which teams?

f. Some teams are not reporting their measures. What do you think are the reasons for this?

5. What aspects of the program were most helpful? What aspects you could have done without? (e.g. thinking of the various components). What were your big 'aha' moments?

6. To what extent have you and your team embraced a culture of quality improvement?

    a. Have you spread this culture to other practices or domains of clinical practice?

7. Finally, in a few words, please tell us what would be the most important thing to do to improve the program.