Learning Collaborative One

An Improvement Journey for Primary Healthcare Teams

Quality Improvement
& Innovation Partnership

Like any journey, it begins with a single step.
This is the story of the Learning Collaborative One
quality improvement journey...

Participating Teams From...

Alliston FHT
Anson General FHT
Blue Sky FHT
Caroline FHT
Country Roads CHC
Credit Valley FHT
Delhi FHT
Dorval Medical FHT
East End CHC
Haileybury FHT
Hamilton - Crown Point FHT
Kingston FHT
LDRS Shared Care Pilot
Maple FHT
Marathon FHT
New Vision FHT
Niagara Medical Group FHT
North Simcoe FHT
Northeastern Manitoulin FHT
PrimaCare Community FHT
Prince Edward FHT
Queen's FHT
Sharbot Lake FHT
Sherbourne FHT
Six Nations FHT
South Algonquin FHT
South East Toronto FHT
Stratford FHT
Summerville FHT
Sunset Country FHT
The Centre for Family Medicine FHT
The Ottawa Hospital Academic FHT
Timmins FHT
Two Rivers FHT
Upper Grand FHT

About QIIP

The Quality Improvement and Innovation Partnership (QIIP) is a provincial organization funded by the Ministry of Health and Long-Term Care. QIIP's goal is to advance the development of a high-performing primary healthcare system. This goal is supported by three interrelated strategies: networking and partnerships; resources and supports; and improvement and innovation methods.

QIIP's vision for a long-term system of improvement in primary healthcare recognizes the need to engage and leverage strategic partnerships with other key organizations and individuals at a regional, provincial, national and international level. In this way, QIIP's activities can build, with others, toward shared outcomes related to a healthier population, improved patient and care team experience and more effective use of resources.

Primary healthcare (PHC) renewal has been identified in Canadian policy and by most health reformers as the foundation in a sustainable healthcare system. The opportunity for PHC to coordinate, integrate and expand systems of care is defined by the following:

- Collaborative care teams;
- Sickness prevention, population health and health promotion;
- Informed research, knowledge translation and quality improvement.

The need to build capacity and capability for quality improvement in primary healthcare in Ontario is being advanced by QIIP initially through the implementation of three Learning Collaboratives based on the Institute for Healthcare Improvement (IHI) Breakthrough Series methodology. Continued engagement of primary healthcare teams in quality improvement will be supported by a Learning Community model that will include a virtual work space for teams to learn, collaborate, innovate and measure their improvements.

The focus on learning and building knowledge are the underpinnings of quality improvement. Since May 2008, 37 Family Health Teams, Community Health Centres and Shared Care Pilot Initiatives from across Ontario have participated in a Learning Collaborative. The collaboration of teams has provided a structure for learning, sharing and action as they make system-level changes that lead to improvements in care.

The teams have engaged in quality improvement work in three areas of focus:

Chronic Disease Care – Diabetes (10 measures)

Preventive Care – Colorectal Cancer screening (2 measures)

Office Practice Redesign – Access & Efficiency (4 measures)

Through the application of the Model for Improvement and the integration of the Plan, Do, Study, Act (PDSA) Cycle for testing change, the participating teams have realized innovative improvements in provider satisfaction, processes and patient/client outcomes.

"There is no substitute for knowledge."

W. Edwards Deming

The Quality Improvement Team

Before quality improvement work began, a primary healthcare team had to be created. For it to be a true collaboration, many different roles within the team needed to be represented. The core teams were composed of:

The Physician Champion
(principal leader at the practice site)

Clinical/Technical Experts
(allied health team members/front office staff)

Team Lead
(day-to-day leadership and coordination)

Reporting Lead
(monthly data collection, reporting and communication)

A learning collaborative not only brings teams together around shared goals, but more importantly, it is a highly effective way to accelerate widespread improvement. A QIIP Practice Facilitator provided external coaching to the team around the integration and application of relevant frameworks to support quality improvement.

The Frameworks for Change

Three frameworks supported the quality improvement efforts of the teams: the Learning Model, the Chronic Disease Prevention and Management framework and the Model for Improvement. The frameworks assisted in closing gaps that existed in the systems of care of the participating teams and in doing so; built the capacity to innovatively move towards planned care, panel management and a population health focus.

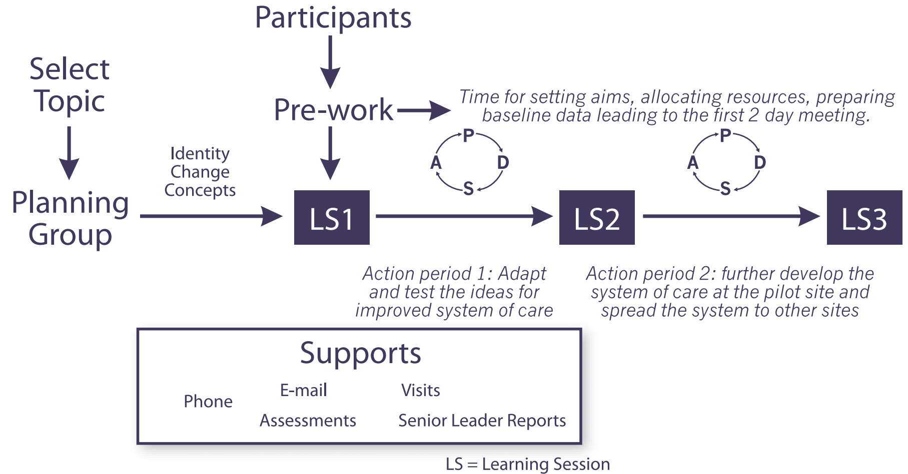
Designed on the IHI's *Breakthrough Series Model*, the QIIP Collaborative incorporated the following elements of the Learning Model:

- Three *Learning Sessions*, which included workshops, teachings, didactic speakers, storyboard presentations and team meetings;
- *Action periods* between each learning session where teams tested change ideas using the improvement methodology of the Plan-Do-Study-Act Cycle.
- *Information technology* was used to help manage the flow of information, learning and activities. Teams were encouraged to post their reports and data on the virtual office and to communicate with one another through a listserv, regularly scheduled teleconferences, and phone and email correspondence.
- *Practice facilitators* well versed in the models, frameworks, tools and data analysis were assigned to each team to assist members throughout their participation.

"We have met on a weekly basis and that itself was one of the most important components; having time to expose each other to our own thoughts, our explorations and the guide being improvement and getting to a level of innovation."

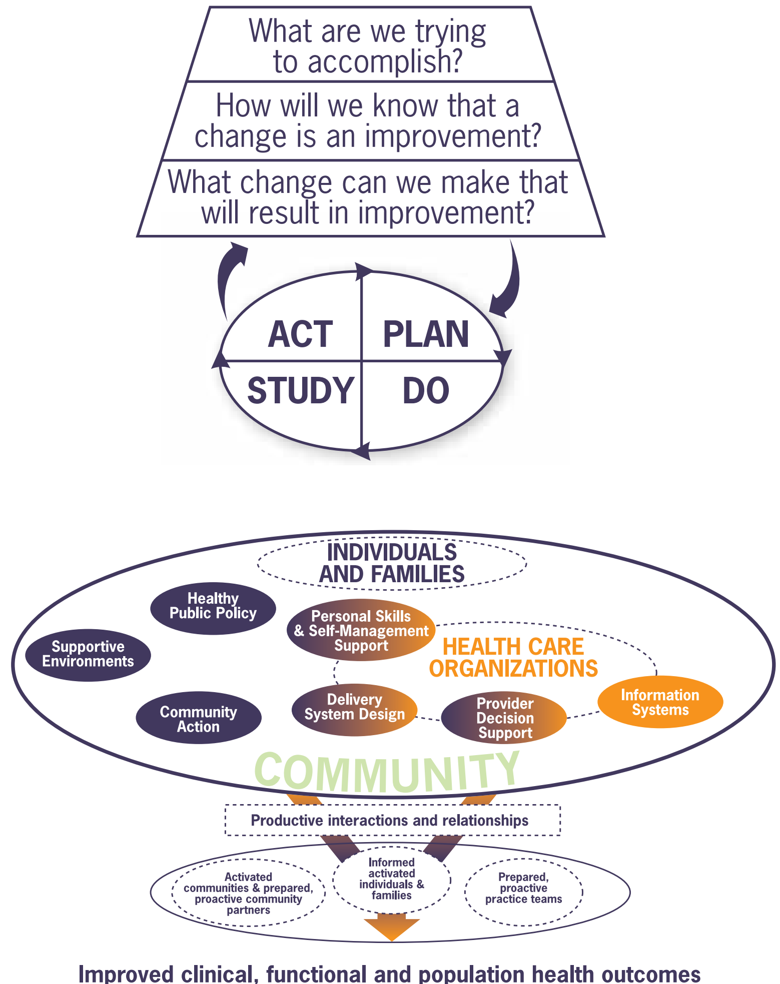
Dr. John MacDonald, PrimaCare Community FHT

The Original IHI Learning Model "Breakthrough Series"



The Model for Improvement was the quality improvement methodology used during the learning collaborative. The Model for Improvement is a strategy for testing, implementing, and spreading practice innovations. It includes the use of plan-do-study-act (PDSA) cycles or rapid cycle tests of change to drive improvement.

Model For Improvement



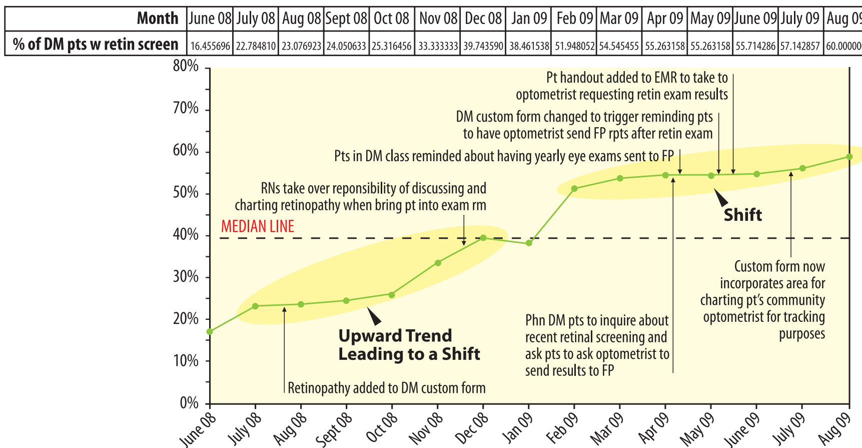
"We don't have to develop a full program, we can start with one small change and it makes such a difference and we have never done that before."

Joyce Phillips, Kingston FHT

The Chronic Disease Prevention and Management framework describes an ideal system of healthcare for chronic conditions. Consisting of six essential components, the framework can also be applied to preventative care.

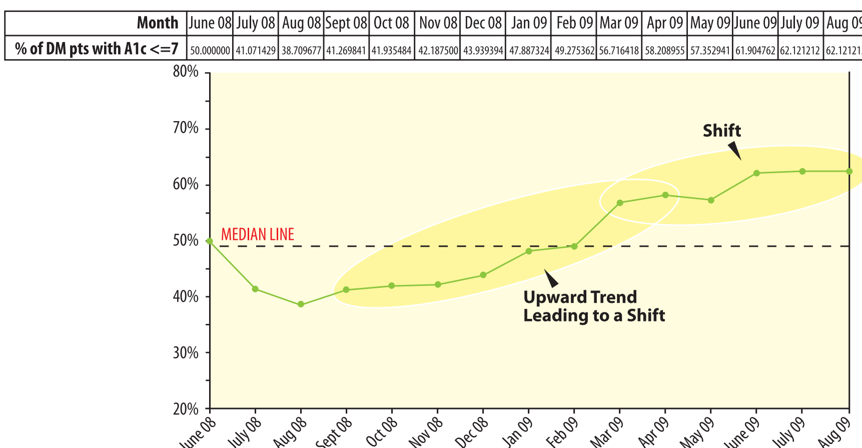
The Learning

New Vision FHT - Percent of DM pts with retinopathy screening in past 730 days



Month	June 08	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	June 09	July 09	Aug 09
% of DM pts w retin screen	16.455696	22.784810	23.076923	24.050633	25.316456	33.333333	39.743590	38.461538	51.948052	54.545455	55.263158	55.263158	55.714286	57.142857	60.000000

New Vision FHT - Percent of DM patients with A1c<=7



Month	June 08	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	June 09	July 09	Aug 09
% of DM pts with A1c <=7	50.000000	41.071429	38.709677	41.269841	41.935484	42.187500	43.939394	47.887324	49.275362	56.716418	58.208955	57.352941	61.904762	62.121212	62.121212

Everyone learns, everyone teaches...

During the 15-month improvement journey, Learning Collaborative One teams have demonstrated incremental improvements in outcomes and processes across the three domains of focus – diabetes, colorectal cancer screening and office practice redesign.

Diabetes

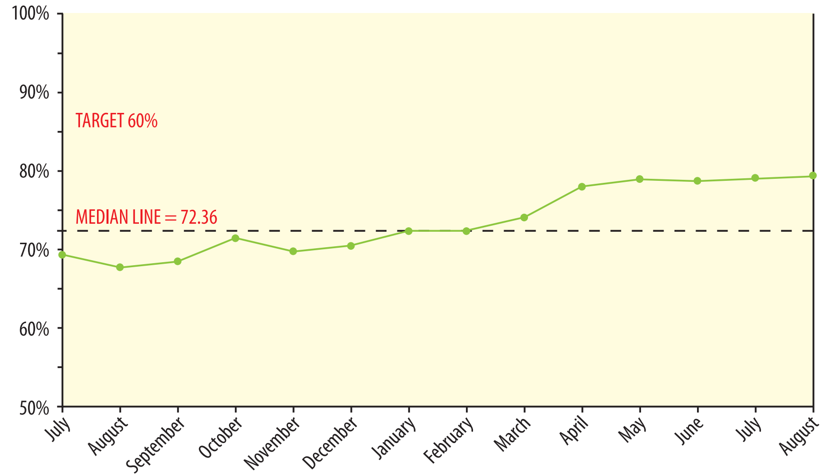
The focus on chronic disease care within the diabetes domain spoke to the potential for proactive, planned care for a panel of selected patients. Improving the patient experience with timely access to evidence-based healthcare was demonstrated by teams that focused on improvement opportunities across the system of care. Using data to display improvement, teams such as New Vision FHT have been able to demonstrate the significant improvement in outcome (A1C target) and process measures (retinopathy screening) for their patients with diabetes. Annotation on data charts has proven invaluable in telling the improvement story and in supporting future sustainability and spread initiatives for the team.

> *"Not only are we changing the way we provide care, but we are changing the way patients are receiving care with the support of the physicians."*
>
> *Amy Horton, New Vision Family Health Team*

Colorectal

The improvement efforts in the colorectal cancer screening (CRCS) domain focused on prevention through the development of screening processes. Testing changes with respect to the role of the care team in these processes as well as incorporating self-management techniques to improve screening rates, demonstrated that increased numbers of patients could effectively receive education and preventative screening.

Timmins FHT CRCS Screening - LC1 2008-09



"Reaching out to our community with a focus on decision support has assisted us to realize improvements in our prevention work around colorectal cancer screening."

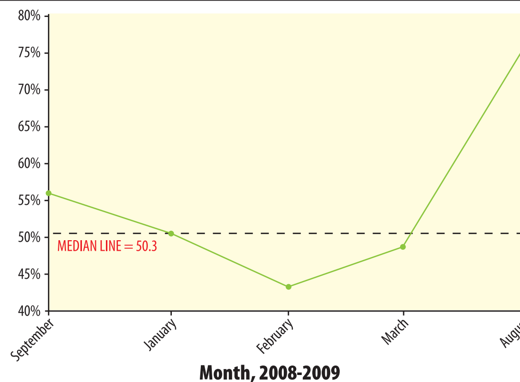
Elisha Laughren, Timmins Family Health Team

Office Practice Redesign

Developing more efficient ways to deliver care in order to move to a model of more proactive, planned care and to optimize utilization of the team is a goal for primary healthcare teams. The learning collaborative assisted teams to think about how to improve access to the care of the primary provider and allied team members. Applying principles that included measuring for next available appointment and continuity (access), cycle time and red zone time (efficiency), the teams that participated in the learning collaborative improved the flow of work, created efficiencies and balanced supply and demand for care. With a focus on an environment where providers can “do today’s work today”, increasingly teams within the learning collaborative have enabled patients to have timely access to the care they need.

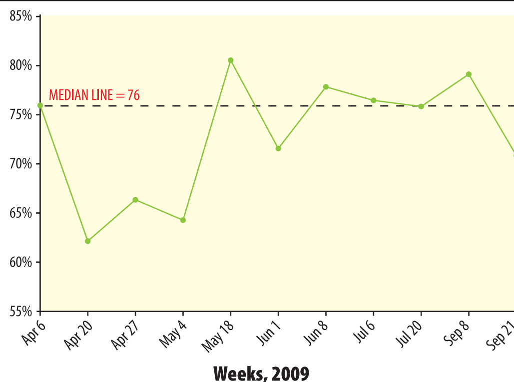
Kingston Family Health Team Percent Red Zone for Dr. Pinkerton

Month	September	January	February	March	August
Red Zone	55.9	50.3	43.1	48.7	76.0



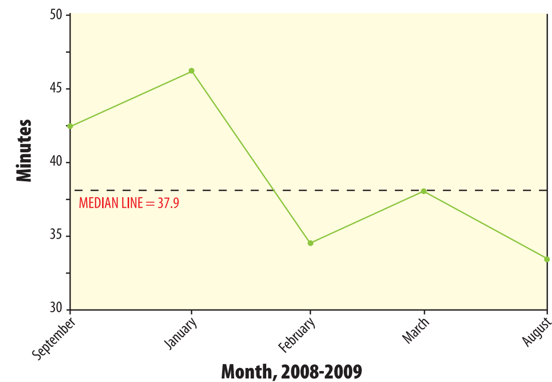
Kingston Family Health Team Percent Open Capacity for Dr. Pinkerton

Week	Apr 6	Apr 20	Apr 27	May 4	May 18	Jun 1	Jun 8	Jul 6	Jul 20	Sep 8	Sep 21
Open Cap	76.1	61.8	66.1	64.3	80.5	71.6	77.2	76.3	76.0	79.0	71.0



Kingston Family Health Team Total Average Cycle Time for Dr. Pinkerton

Month	September	January	February	March	August
Red Zone	42.5	46.1	34.6	37.9	33.6



“Everyone is happier at work with advanced access. The whole flow is better, the patients are happier, from the front desk all the way to me. It’s been wonderful.”

Dr. David Pinkerton, Physician, Kingston FHT

Embracing the Opportunity - The Journey Continues

Sustaining the gains is an important part of quality improvement work. As teams completed the learning collaborative, they found themselves not only still implementing changes but also preparing to spread sustainable changes to others in the organization. The sustainability and spread focus of the improvement work was supported by QIIP with specific tools and training, enhancing quality improvement work into the future for the Learning Collaborative One teams.

With the knowledge, tools and supports in place, the Learning Collaborative One teams have begun to build and strengthen their capacity and capability for quality improvement efforts. The ability to begin to transform the systems that deliver primary healthcare has been a highlight of the quality improvement journey and has paved the way for future initiatives. The new system of primary healthcare delivery will be one where patients:

- Can get a “same day” appointment with their physician;
- Are seen promptly when they arrive in the healthcare clinic;
- Have a central role in managing their health and are provided with the tools and support required to do so in a planned care format;
- Receive reminders from their primary healthcare provider about important screening tests and necessary follow-up visits.

With an additional focus on provider satisfaction and emphasis on learning, sharing and improvement, primary healthcare teams will continue to improve and innovate the healthcare they deliver.

Acknowledgment

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Resources

*Commission on the Future of Healthcare in Canada, 2002; Standing Senate Committee on Social Affairs, Science and Technology, 2002; Health Council of Canada, 2005.

Quality Improvement and Innovation Partnership (QIIP) www.qiip.ca

Association of Ontario Health Centres (AOHC) www.aohc.org

The Institute for Healthcare Improvement (IHI) is a Boston-based, not-for-profit organization dedicated to accelerating the transformation of healthcare globally. The IHI developed the Breakthrough Series Collaborative model, which has been applied internationally as a vehicle to accelerate change. www.ihi.org

Ontario's Chronic Disease Prevention and Management Framework
www.toronto.ca/health/resources/tcpc/pdf/conference_lee.pdf

Health Council of Canada www.healthcouncilcanada.ca

Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. "The Improvement Guide: A Practical Approach to Enhancing Organizational Performance."

The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle.

Commission on the Future of Healthcare in Canada, 2002; Standing Senate Committee on Social Affairs, Science and Technology, 2002; Health Council of Canada, 2005.

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