Learning Collaborative Two

An Improvement Journey for Primary Healthcare Teams

Quality Improvement
& Innovation Partnership

November 2008 to
January 2010

www.qiip.ca

Mission

The Quality Improvement and Innovation Partnership will be the provincial leader in quality improvement methods for primary healthcare.

Vision

Ontario's primary healthcare system will be recognized as providing exemplary primary healthcare driven by a commitment to continuous quality improvement.

Goal

To advance the development of a high performing primary healthcare system.

As 31 teams embarked on the second wave of Quality Improvement and Innovation Partnership's Learning Collaboratives, the importance of a strong foundation for teamwork was recognized as a key component for quality improvement success. This is the story of the Learning Collaborative Two.

Participating Teams From...

Athens and District FHT
Bancroft FHT
Bridgepoint FHT
Brockville FHT
Bruyère Academic FHT
Carefirst FHT
Central Hastings FHT
Cottage Country FHT
Couchiching FHT
Dryden Area FHT
Fenelon Falls FHT (now Kawartha North FHT)
FNAM – Plantaganet Shared Care Pilot
Fort Frances FHT
Guelph CHC
Haldimand FHT Dunnville
Hamilton FHT – Core Care
Harrow Health Centre FHT
Huron Community FHT
McMaster FHT
Minto-Mapleton FHT
Parry Sound FHT
Regent Park CHC
Rideau FHT
STAR FHT
Summerville FHT
Taddle Creek FHT
Tilbury District FHT
West Elgin CHC

About QIIP

QIIP is a provincial organization funded by the Ministry of Health and Long-Term Care with the goal of advancing 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[1] 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[2] 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 IHI Breakthrough Series[3] 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 Learning Community will be introduced in late spring and we welcome you to participate to sustain your improvement and take on the challenge of additional areas of focus.

The focus on learning and building knowledge are the underpinnings of quality improvement. Since May 2008, Family Health Teams, Community Health Centres and Shared Care Pilot Initiatives from across Ontario have participated in Learning Collaboratives. 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 big change is going from episodic care to patient management, and it's getting a doctor going from one-on-one encounters to managing a whole healthcare system…as far as healthcare in the future, it's certainly the way to go."

Dr. Christopher Cressey, Minto-Mapleton Family Health Team

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 Coach or Practice Facilitator provided external coaching to the team around the integration and application of relevant frameworks to support quality improvement.

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

Chronic Disease Care – Diabetes
Preventive Care – Colorectal Cancer screening
Office Practice Redesign – Access & Efficiency

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 outcomes.

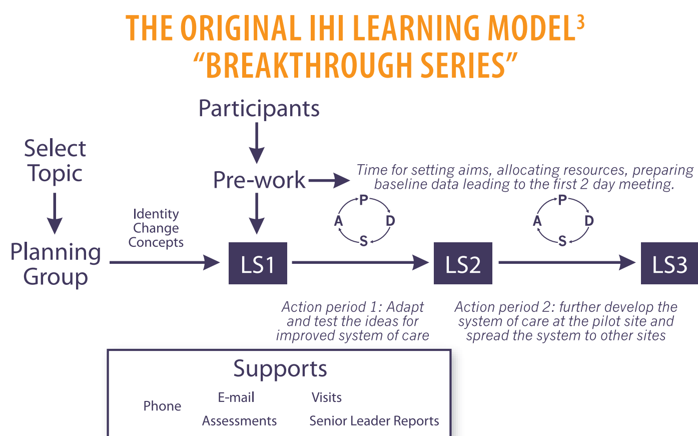
The Frameworks for Change

Three frameworks supported the quality improvement efforts of the teams: the Learning Model[3], the Model for Improvement[4] and Chronic Disease and Prevention Management Model.[5] 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.

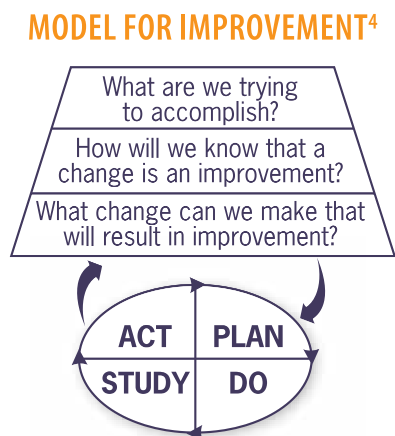
Designed on the Institute for Healthcare Improvement's *Breakthrough Series Model*[3], the QIIP collaborative incorporated the following elements of the Learning Model:

- 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* or Quality Improvement Coaches well versed in the models, frameworks, tools and data analysis were assigned to each team to assist members throughout their participation

THE ORIGINAL IHI LEARNING MODEL[3] "BREAKTHROUGH SERIES"



MODEL FOR IMPROVEMENT[4]



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.

CHRONIC DISEASE PREVENTION & MANAGEMENT MODEL[5]

Improved clinical, functional and population health outcomes

The Chronic Disease & Prevention Management Model is a framework for an ideal system of healthcare for chronic conditions. Consisting of six essential components, the model can also be applied to preventive care.

> *"The team demonstrated persistence from the very start. They were committed to implementing change and seeing it succeed because the change could be made within the organization's existing structure"*
>
> *Dr. Jason Datema, Huron Community Family Health Team*

Team Work in Action

During the 14-month improvement journey, teams participating in the second Learning Collaborative demonstrated improvements in the three domains of focus: diabetes, colorectal cancer screening and office practice redesign. Not only have teams focused their improvement challenge in these areas, they have also had the opportunity to build stronger relationships with their team members. Each organizaiton participating in the Learning Collaborative has formed a Quality Improvement Team (QI team) comprised of a physician, registered nurse or nurse practitioner, other health professionals, and an administrive support staff member. The QI team members attend learning sessions, oversee the process of change, review data, ensure key components of change are in place and manage changes within the organization.

Diabetes

The focus on chronic disease management provided teams with the necessary resources for a proactive and planned approach to their panel of selected diabetic patients. Improving the patient experience was realized by teams who focused on improvement opportunities across the system of care. Teams like Regent Park Community Health Centre have used improvement tools to become a more proactive and prepared team, to inform and engage their patients while maintaining the goal of improving outcomes.

Supporting Patient Self-Management and Education: Regent Park Community Health Centre

Inspired by their involvement in QIIP's Collaborative Learning Sessions and understanding the need to spend time with patients to ensure consistent health messaging and collaborative goal setting, Regent Park CHC created an interdisciplinary Diabetes Clinic. The key players in the improvement journey of establishing, implementing and testing the clinic were Dr. Tara Kiran, Physician, Eleanor Tyrell, Diabetes Nurse Educator and Raquel Figueroa, Registered Dietitian.

The main focus of the Diabetes Clinic was to identify and address the needs of patients who were challenged by social, economic and complex health issues. Their approach was to enhance and ensure consistent communication and internal collaboration. Through the use of PDSA cycles and the creation of a one-page Low Literacy Diabetes Passport, Regent Park CHC cited the following positive outcomes resulting from the new Diabetes Clinic:

- **Improved communication** between clinicians and patients. The Low Literacy Diabetes Passport was used to engage patients in goal setting, care planning, test result interpretation and provided motivation and reinforcement in self-management. Used as a visual representation of patient progress, as many of Regent Park CHC's patients struggle with English as a second language, through the use of symbols and a three-coloured sticker approach (red, yellow, green) which signified areas of concern and/or positive results.
- **Increase team members' full scope of practice** by involving interdisciplinary health professionals in program planning and implementation; providers are able to better understand the barriers of self-management for patients; no-show appointments have decreased and have allowed providers to use their time more efficiently and clinicians feel that they are working more effectively together as a team and are learning from one and other.
- **Introduction of a New Tool:** The one-page Low Literacy Diabetes Passport, a simplified record keeping tool, has greatly assisted providers and team members in conveying consistent messaging and cohesive care planning for their patients.

Regent Park CHC realized they had an opportunity to share and spread their improvement with others. They did this by sharing their improvements and promoting enhanced team functioning. The diabetes care team shared their successes and their collaborative work plan with other colleagues. As a result, the Diabetes Clinic program has now been incorporated in the practice of another Regent Park CHC physician and has played a role in advancing quality improvement in the diabetes domain.

"We found that it's worked really well for improving team collaboration, improving learning between team members, improving consistent messaging towards the patient and helping to engage the patient in their own care."

Dr. Tara Kiran, Regent Park Community Health Centre

Improved Colorectal Cancer Screening Rates

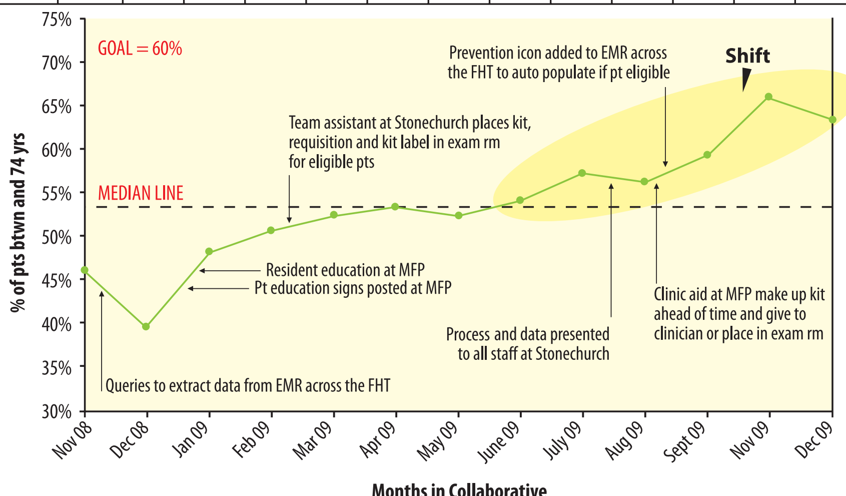
Preventative Care: Colorectal Cancer Screening

An area of focus for the primary health care teams participating in the collaborative was on disease prevention with the goal of improving screening rates for colorectal cancer. The teams identified, tested and implemented several new patient centered processes that had a positive effect on their screening rates. Highlighted in this report are two teams, McMaster Family Health Team and Bancroft Family Health Team. They were successful in realizing an improvement in the percentage of patients screened for colorectal cancer by implementing change that was effective.

MCMASTER FAMILY HEALTH TEAM
PERCENT OF ELIGIBLE PATIENTS WITH FOBT OR COLONOSCOPY

AN IMPROVEMENT IN THE % OF PATIENTS SCREENED FROM 46% TO 63%

Month	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	June 09	July 09	Aug 09	Sept 09	Nov 09	Dec 09
% w CR screen	45.614035	39.686099	47.178330	50.904977	52.631579	53.258427	52.325581	54.101996	57.608696	56.347439	59.322034	66.666667	63.215859



Spreading the Gain: McMaster Family Health Team

Two teams from McMaster Family Health Team participated in QIIP's second collaborative – McMaster Family Practice and Stonechurch Family Health Centre. While the two teams experienced their own journeys within the collaborative, both teams tested and implemented changes which maximized the use of electronic medical records (EMR), maximized the roles of team members and streamlined the CRCS process. The new process is shared across the Family Health Team and between the team assistant/clinic aid, the care giver and the patient. These improvement approaches have been spread to other staff members across the Family Health Team and have been expanded to include other areas for prevention such as breast and cervical cancer and immunizations.

Implementing Change: Bancroft Family Health Team

Bancroft Family Health Team utilized various approaches to improve and increase their CRCS rates for patients 50 to 74 years of age. Recognizing barriers from the patient perspective and their ability to identify eligible patients, they aggressively tested and improved their processes. Implementation of multiple changes and approaches that engaged their patients resulted in a big shift in the percentage of patients screened.

Improved Patient Identification

- The clinic process was redesigned to successfully identify and flag patients who were eligible for CRCS. Roles and responsibilities of team members were maximized to increase the efficiency process of screening appropriate patients. Team members who worked on this process were: Physician, Nurse Practitioner, Billing/Prevention Clerk, IT Personnel, Chronic Disease Nurse and Administrative Staff. Eligible patients were flagged with a "sticky" in their EMR, which prompted the physician and clinical staff to remind the patient that they did not have a fecal-occult blood test (FOBT)result in their file.

Improved Referral Process

- Colonoscopy referrals, from local healthcare facilities, were loaded into the EMR database for ease of access during a patient's office visit.

Improved Patient Education

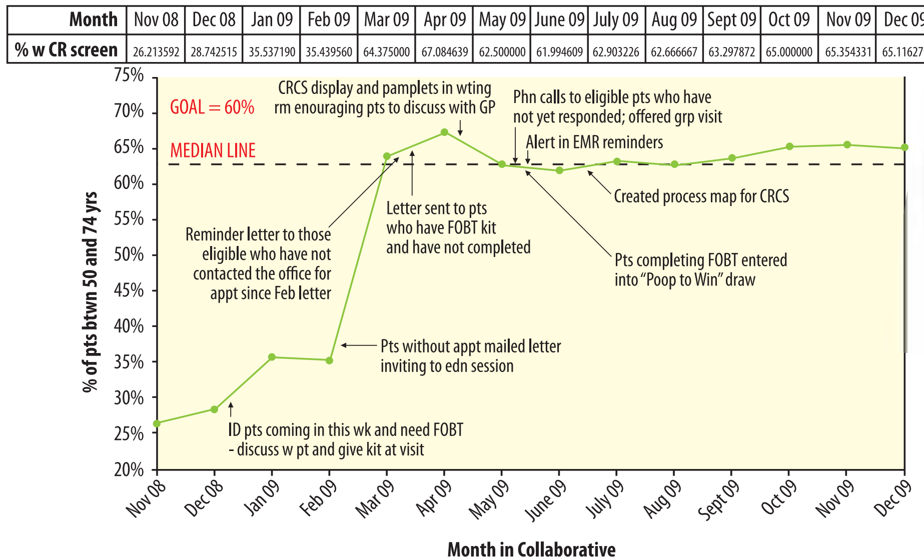
- A wall-sized colorectal display was hung in the waiting area, along with pamphlets, to inform and encourage eligible patients to discuss CRCS with their physician. The display provided facts about colorectal cancer, screening methods and risk reduction. Staff members held public information sessions at local pharmacies to provide education on CRCS.

Improved Follow-up

- Upon the return of FOBT kits, patients were told that they had been entered into a draw for prizes. Patients who had not come to the office were sent letters and then received follow-up phone calls.

BANCROFT FAMILY HEALTH TEAM
PERCENT OF ELIGIBLE PATIENTS SCREENED WITH FOBT OR COLONOSCOPY

COLORECTAL SCREENING RATE INCREASES FROM 26 TO 65%



Month	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	June 09	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09
% w CR screen	26.213592	28.742515	35.537190	35.439560	64.375000	67.084639	62.500000	61.994609	62.903226	62.666667	63.297872	65.000000	65.354331	65.116279

39% INCREASE IN COLORECTAL CANCER SCREENING RATES

> *"QIIP inspired us to 'just do it.' Start small and show others the results."*
> *Dr. Carolyn Brown, Bancroft Family Health Team*

Improving Access

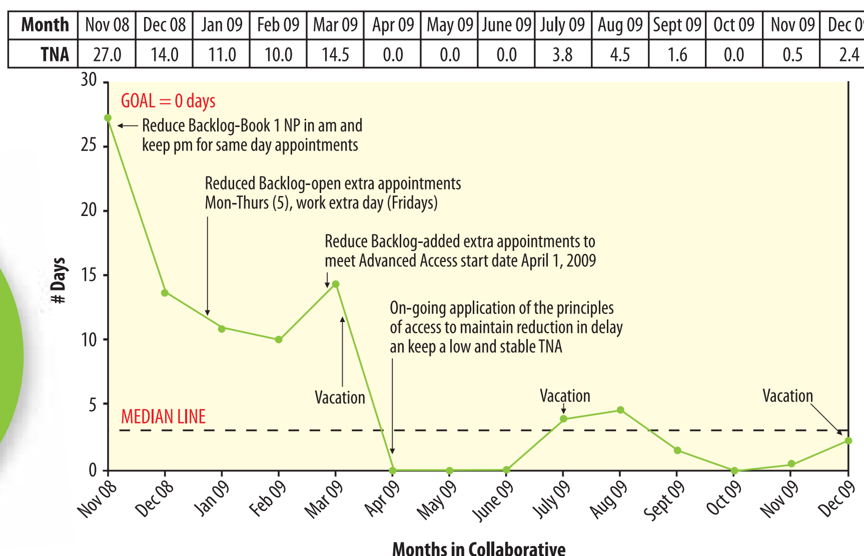
Office Practice Redesign

Across Ontario, primary healthcare providers participating in the second Learning Collaborative are redesigning how they deliver services to provide care that is focused on "doing today's work today". Teams are implementing changes that focus on improving access that is effective, comprehensive, patient-centered and team based. The results are encouraging as teams have increasingly enabled patients to receive timely access to the care they need. Developing more efficient ways to deliver access was achieved as teams moved to a model of proactive and planned care. Applying principles that include measuring for next available appointment, cycle time and red zone time (efficiency), has demonstrated an improvement in the flow of work, created efficiencies and balanced the supply of care to meet the demand.

With the goal of reducing the average time to the third next available (TNA) appointment, the Athens and District Family Heath Team was successful in achieving this goal. As illustrated in the corresponding run chart for Dr. Ben Stobo, the average time to the third next available appointment was decreased from 27 days to zero days. A small amount of fluctuation occurred over time and the team has identified and understands what influenced the fluctuations. Congratulations to the Athens and District Family Health Team on this important accomplishment.

Improving Access, a major reduction in waiting times to third next available appointment

ATHENS AND DISTRICT FAMILY HEALTH TEAM
AVERAGE TIME TO THIRD NEXT AVAILABLE (TNA) APPOINTMENT FOR DR. BEN STOBO



Month	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	June 09	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09
TNA	27.0	14.0	11.0	10.0	14.5	0.0	0.0	0.0	3.8	4.5	1.6	0.0	0.5	2.4

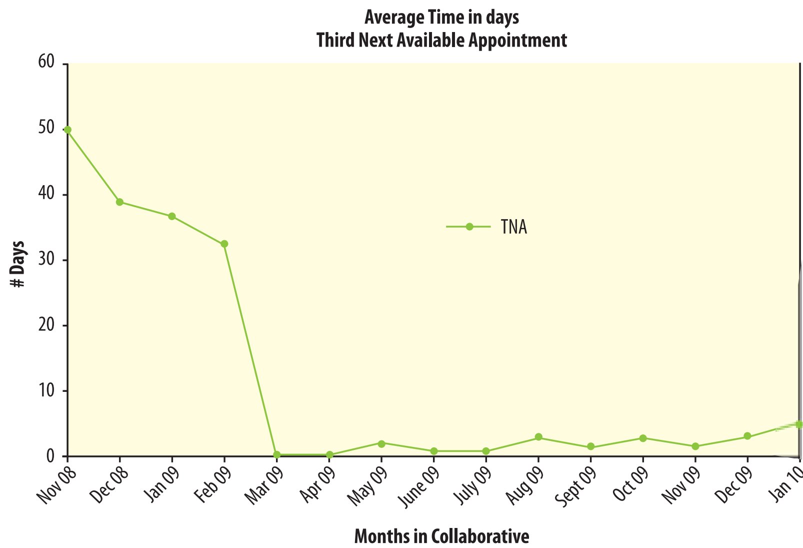
The Athens and District Family Heath Team reduced the waiting time to the third next available appointment from 27 days to 0 days.

> *"When you're not always reacting to the emergent, you have time to be creative and that's what is happening in our office now."*
> *Dr. Ben Stobo, Athens and District Family Health Team*

Easy Access Pilot

Dr. Sharon Gazely and the Advanced Access team members: Enrique Saenz, Clinical Operations Manager, Poonam Ohri, Medical Secretary and the reception staff of the Regent Park Community Health Centre have drastically reduced time to the third next available (TNA) appointment. They have also reduced the number of occasions of patient no-shows since implementing their ***"Easy Access Pilot"*** in May 2009. Dr. Gazely has been able to reduce the time of TNA from a high of 50 days to an outstanding low of 0-5 days. The no-shows occurrences have dropped as well as illustrated in the corresponding chart from 33 occasions in one month to a low of three occasions. Slight rises in TNA data can be explained by vacation and illness, and increases in no-shows are due to patients who pre-booked and did not keep their appointment.

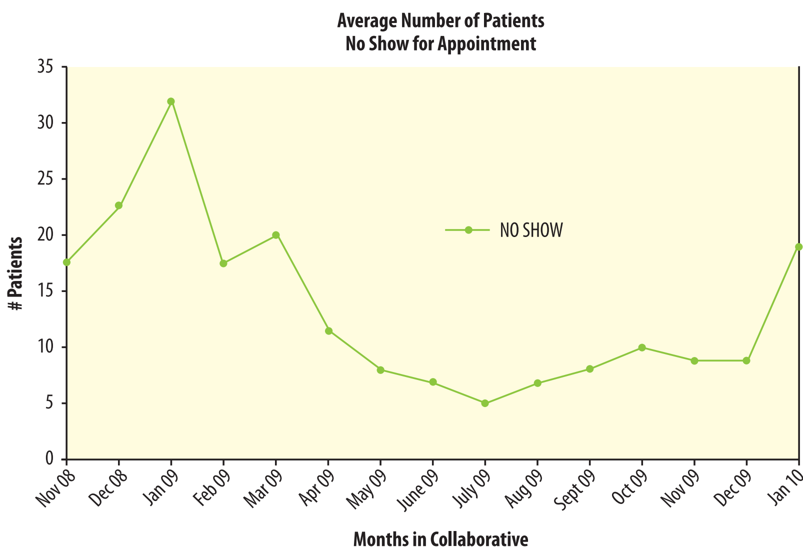
REGENT PARK COMMUNITY HEALTH CENTRE "EASY ACCESS PILOT"
AVERAGE TIME TO THIRD NEXT AVAILABLE APPOINTMENT FOR DR. SHARON GAZELY



THIS IS IMPROVEMENT

An important reduction in the wait time to Third Next Available Appointment. A reduction from 50 days to 0-5 days.

REGENT PARK COMMUNITY HEALTH CENTRE "EASY ACCESS PILOT"
AVERAGE NUMBER OF PATIENTS WHO DID NOT SHOW FOR THEIR APPOINTMENT FOR DR. SHARON GAZELY



The Quality Improvement COACH (Practice Facilitators)

For more than two-years, QIIP's Practice Facilitators, now referred to as QI Coaches have supported the implementation, data measurement and spread and sustainability of quality improvement work in the primary healthcare system. Located across Ontario, QI Coaches are assigned to participating Family Health Teams, Community Health Centres and Shared Care Pilot Initiatives based on their geographic proximity to the teams. They lend their expertise to participants in the domains of clinical knowledge, quality improvement methodology, facilitation, communication and information management.

Seven key roles of the QI Coach are:

- Quality Improvement Expert
- Communicator
- Collaborator
- Systems Thinker
- Manager
- Scholar and Educator
- Leader

Leadership is a key component that enables teams to optimize quality improvement, achieve breakthrough successes within their respective practices and assist teams in building strong foundations for collaborative and innovative teamwork.

QI Coaches have identified five key characteristics for team success: team effectiveness and functioning, information management, tracking organizational performance, leadership support, quality improvement capacity and the adoption of a culture of continuous quality improvement.

With the tools and knowledge in place to build quality improvement capacity and capability, teams are able to sustain, strengthen and spread changes that lead to improvement to others within the organization. Aligned with the support of their QI Coach, Family Health Teams, Community Health Centres and Shared Care Pilot Initiatives are improving and innovating the way they deliver primary healthcare in Ontario.

"It's a privilege when a team allows me to support them along their journey of quality improvement. Sometimes my role is that of a coach - encouraging team members; sometimes my role is that of facilitator - supporting the team through a difficult discussion, and other times my role is that of a trainer - exploring QI methodology. At the core is the development of a respectful relationship which then allows me to respond to the team in the most supportive role for them at that moment."

Tricia Wilkerson, Quality Improvement Coach

Acknowledgment

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2. 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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4. Model of Improvement: The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. “The Improvement Guide: A Practical Approach to Enhancing Organizational Performance.”
5. Ontario’s Chronic Disease Prevention and Management Framework: www.toronto.ca/health/resources/tcpc/pdf/conference_lee.pdf

Resources

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

Health Council of Canada www.healthcouncilcanada.ca

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