Collaborative Charter

Quality Improvement and Innovation Partnership (QIIP)
Learning Collaborative Charter

Background

In 2005, The Ontario Ministry of Health and Long Term Care embarked upon a series of strategic initiatives aimed at improving the health status of Ontarians. One of these initiatives was the reorganization of the primary care system through the formation of 150 Family Health Teams (FHTs). The mission of these FHTs was to improve access to effective, comprehensive, patient centred, team based primary health care which supports self-management; emphasizes health promotion and illness prevention, and enhances the management of individuals with chronic diseases. These FHTs were expected to develop high quality programs that were well linked with other local health and community programs. One hundred and fifty FHTs have been authorized to date, with an expectation for additional growth of FHTs in the future.

The Ministry recognized that the shift from the traditional reactive model of health care delivery to a proactive planned approach would present significant challenges. Incentives, in the form of differential payments based on achievement of quality goals, were established. In addition, the Quality Management Collaborative (QMC)[1], now known as the Quality Improvement and Innovation Partnership (QIIP), was established to provide support, resources and guidance to assist FHTs with the transition to the new health care system.

Over the last year QIIP has explored the experience of other provinces as well as international models for health care transformation. A decision was made to adapt an adult learning model developed by the Institute for Healthcare Improvement[2] and to apply it in Ontario. The adult learning model, known as the Breakthrough Series Model, provides a mechanism to accelerate transformation through a structured peer based collaborative learning approach. A decision was made by QIIP to use this model to focus on three core topic areas-- colorectal screening, diabetes management and improved access and office efficiency. These three topic areas represent a proxy for the ability of FHTs to handle acute, chronic and preventive issues in an efficient and patient centred manner. Three cohorts of FHTs will come together in a staged process in the form of Learning Collaboratives, beginning in May 2008. This document sets forth the Charter for each of these Collaboratives.

Problem Statement

The burden of chronic disease in Ontario is rising rapidly. Approximately 83% of Ontarians over age 45 (nearly 4 million) have a chronic disease, of which 70% (2.78 million) suffer from two or more. Over 55% (or $32 Billion) of total direct and indirect health care costs are attributable to chronic diseases. Yet patients continue to be treated in a system that is focused on the delivery of reactive versus proactive care and is single patient versus population-based. Care is usually delivered within the confines of very short face-to-face encounters with overbooked, under-resourced providers. As a result patients are not receiving the evidence-based care we know they need, in a timely fashion. Nor are they consistently receiving care in a timely fashion.

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[1] QMC was renamed the Quality Improvement and Innovation Partnership (QIIP) in April 2008

[2] ***The Institute for Healthcare Improvement (IHI) is a Boston based not for profit organization dedicated to accelerating the transformation of health care globally. The IHI developed the BreakThrough Series Collaborative model which has been applied internationally as a vehicle to accelerate change.***

As the number of Ontarians with chronic illness increases, the strain on the system will be evidenced by suboptimal clinical outcomes, inadequate delivery of preventive care services and longer wait times for accessing care.

Currently 8% of Ontarians have diabetes (approx. 900,000 people); this number has been growing at an alarming rate and is expected to increase another 75% by 2016. The burden on the health system is significant, with nearly one in ten hospital admissions occurring as a result of the complications of diabetes. Diabetes is responsible for almost 10% of the total direct costs of the Ontario health care system. Despite knowing the positive impacts that lifestyle and evidence –based care can have in the diabetic population, it is estimated that:

- 60% of people with diabetes have gone more than a year without having their eyes checked[3]
- More than 50% of type 2 diabetics are not at recommended blood glucose targets[4]
- Less than 50% of type 2 diabetics are tested for A1c levels, blood pressure, cholesterol, or kidney function.[5]

Similarly, of the Ontarians were eligible for colorectal cancer screening in 2004-2005, only 17% received screening with a fecal occult blood test. Of the estimated 7800 colon cancers that will be detected in 2007, more than 3200 will prove to be fatal, mostly because of late detection. Despite colon cancer being 90% curable, Ontario has one of the highest colon cancer death rates in the world! We can do better.

These disease and primary prevention outcomes are symptomatic of a system overtaxed with acute care needs in addition to the burgeoning demand for chronic and preventive care. Currently the average wait time for an appointment with a family practitioner is x days. Wait times once in the office average xx minutes. And of those Ontarians who have a family practice provider, they are able to see their provider of choice only x% of the time.

The evidence base is increasingly growing and best practices abound. For example, we know that:

- Colorectal screening by fecal occult testing could reduce mortality by 15-33% in the 50-75 age group
- In one key study, each 1% reduction in A1c level was associated with a 37% decrease in risk of damage to blood vessels, 14% reduction in heart attack rates, and 21% reduction in deaths due to type 2 diabetes[6].

A gap exists between what we know and what we practice. The mission of the collaborative for Family Health Teams will be to close these gaps.

The aim of the collaborative will be to employ the Breakthrough Series Learning Model to improve the care of participating FHT teams' rostered patients by achieving certain goals in defined key measures by July 2009.

Collaborative Methodology

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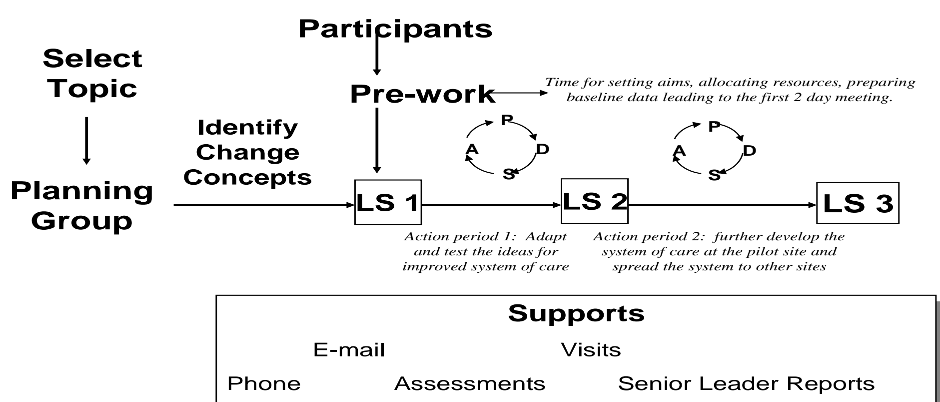
[3] ***Health Ministry source from Nick Kates PowerPoint***
[4] ***Canadian Diabetes Association***
[5] ***Health Council of Canada, Why Healthcare Renewal Matters: Lessons from Diabetes, March 2007***
[6] ***UKPDS Study, Lancet 12 Sept. 1998.***

Three collaborative, each involving up to 50 Family Health Teams (FHTs) will be launched by early 2009. Each of the three Collaboratives will utilize an adaptation of the IHI Breakthrough Series Model presented in Figure 1. The model includes several important design attributes including:

- Use of evidence based changes packages that allow FHTs to focus on easy to implement opportunities for improvement
- Structured monthly reporting on a common core set of measures
- Technical assistance from expert faculty and subject matter experts as well as from facilitators in the field
- The use of web-based technology to assist in communication and shared learning among the various FHT's and to support a knowledge management portal where resources, reports, and documentation of best practices can be housed and shared.
- Monthly telephonic and periodic face to face learning opportunities to accelerate learning and adaptation of concepts to the local environment

Figure 1: The IHI Breakthrough Series Learning Model[7]



The Collaboratives are focused around several face to face learning sessions. In between the structured learning sessions are "action periods." During action periods, teams will use the Model for Improvement and the Care Model to re-design and improve the care delivery systems within their practices. The Model for Improvement is a strategy for testing, implementing, and spreading practice innovations. It includes use of plan-do-study-act (PDSA) cycles or rapid cycle improvement. The Care 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. Both the Model for Improvement and the Care Model will be discussed on Pre-Work conference calls and also covered in detail at the first learning session.

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[7] ***The IHI Breakthrough Series model has been successfully deployed on colorectal screening, diabetes management and improving access in other health care environments. This model has also been successfully adapted in other Canadian provinces.***

Throughout the Collaborative teams will interact with each other, with the facilitators, and with the Collaborative leadership through learning sessions, listservs, conference calls, a web site for the Collaborative, a virtual office, and sharing of reports. During action periods, the listserv and virtual office will be helpful for sharing tools and lessons learned, obtaining answers to questions, generating ideas for removing barriers, and identifying resources. Teams will be expected to use data to monitor their improvement efforts and once per month, team and aggregate progress will be assessed through the review of the core collaborative measures and narrative summary reports prepared by the teams.

Partners

The Quality Improvement and Innovation Partnership has a vision for a long term system of improvement. In order to achieve this vision it recognizes the need to engage and leverage strategic partnerships with:

Ontario Health Quality Council: The Ontario Health Quality Collaborative will serve as an important partner in the process. The partnership will include membership on the Collaborative Planning Group; serving as faculty for the learning sessions, and developing additional training modules as the needs evolve for FHTs

CSI Solutions, LLC: Technical support as an innovation partner will be provided by CSI Solutions, LLC. CSI has been providing technical support of innovative community based collaborations in numerous settings and brings the technical expertise necessary to ensure success of the Collaboratives. .

Planning Group: A Planning Group will be established for each Collaborative. This group will include key stakeholders and faculty and will provide the project team with important feedback and guidance as the process moves through its life cycle. The Planning Group will also reflect on progress toward the aims statement and provide input based on analysis off current trends and themes from the FHTs

Expectations of the Various Stakeholders

Project Team Responsibilities

- Provide evidence-based information on subject matter, application of that subject matter and methods for measurement and process improvement, both during and between Learning Sessions.
- Offer coaching and training to participating organizations.
- Provide communication strategies, such as a virtual office and listserv, for organizations and colleagues during the Collaborative.
- Analyze monthly reports and provide timely follow up to participating practices, as well as the Planning Group.
- Train and support facilitators who will work with participating teams
- Provide funding for travel, accommodation and meals to enable teams to participate in the learning sessions
- Assist with the implementation of Quality Improvement Teams

- Assist with solving problems as they arise

Participating FHTs' Responsibilities:

- Engage the staff in efforts to improve care for patients as set forth by the Collaborative through well defined measures and testing.
- Connect the goals of the Collaborative to a strategic initiative in the organization.
- Provide a forum for regular interaction between the Collaborative team and the organization's senior leadership to review progress, discuss barriers and support needed.
- Select a team to include a physician, nurse or nurse practitioner, at least one other clinician (e.g., pharmacist, dietitian, mental health counselor), a receptionist or medical office assistant, and an administrator.
- Free up time for team members to participate Learning Sessions, team meetings, cross training, and to implement and test changes in the practice.
- Provide team members with electronic mail and access in the clinical area to a computer daily. Email and accessing the collaborative virtual office and listserv will be the primary means of communication among Collaborative team members.
- Develop internal quality improvement strategies to sustain change and promote innovation.
- Complete all Pre-Work requirements prior to Learning Session 1.

FHT QI Team Responsibilities

- Assure monthly reports are turned in on the due date.
- Collect data as defined by the Collaborative **at least monthly**, and plot the data over time as part of the monthly report.
- Share experiences and data openly so that knowledge and learning can be summarized.
- Present a storyboard at each learning session that documents data, progress and experience of the participating practice.
- Assure that at least one team member attends each monthly conference call
- Continue to sustain and spread their improvements to other practices and providers within the FHTs after the end of the collaborative.
- Take the learning from participating teams and begin spread changes to other chronic conditions, preventive screening practices and office efficiencies
- Use information technology to deliver population-based care.