Building Capability and Capacity for Quality Improvement in Primary Healthcare in Ontario

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THE CONTINUED GAPS IN PHC PERFORMANCE

Commonwealth Fund international comparisons show Ontario continues to lag behind best performers in:

- Access
- Care management
- Health information technology and office systems
- Performance monitoring
CONTEXT FOR A NEW APPROACH

• Inadequate outcomes for chronic disease
• Lack of illness prevention and health promotion
• 10% of Ontarians with no family physician (in 2005)
• Lengthy waiting times for primary healthcare
• Need to improve provider satisfaction/retention
• Need to better utilize other staff
THE APPROACH TO CHANGE

• Family Health Teams (FHTs) as a new model of primary healthcare in Ontario
  • Team-based care
  • Rostered patients
  • Capitation-based blended physician payment
  • Chronic disease prevention and management

• The Quality Improvement and Innovation Partnership (QIIP) as a provincial organization to support FHTs
  • Networking, resources, supports
  • Quality improvement
THE IMPROVEMENT OPPORTUNITY

To advance the development of a high-performing primary healthcare system by:

• Building capability and capacity in quality improvement
  • office practice redesign (access and efficiency)
  • clinical areas of focus
• Sustaining improvements/holding the gains
• Spreading to
  • other PHC practices
  • other areas of clinical focus
Capability and capacity building for quality improvement in Primary Healthcare

**Foundational Support**
- Resources, Networks, Partnerships

**Quality Improvement**
- Learning Collaboratives
  - FHTs + CHCs

**Sustainability and Spread**
- Learning Community
  - All PHC Models

- 2007: *Foundational Support*
- 2008-09: *Quality Improvement*
- 2009-10: *Sustain*
- 2010-11: *Spread*
QIIP’s QI Milestones

• Three provincial level Learning Collaboratives
  – 121 teams from primary healthcare practices
  – Collaborative 1, 2, 3 (May 2008 – May 2010)
  – Three domains of focus for improvement
    • Chronic Disease Management (diabetes)
    • Preventive Care (colorectal cancer screening)
    • Office Practice Redesign (access & efficiency)

• Designing and launching the Learning Community
  – 150 teams starting with wave 1 (September 2010 – May 2011)
  – 6 Action Groups (OPR, Diabetes, Hypertension, COPD, Asthma, Integrated Cancer Screening)
  – Planning for future waves and expansion to all PHC models
TRANSITIONING: LEARNING COLLABORATIVE TO LEARNING COMMUNITY
LESSONS LEARNED: THE 3 ESSENTIALS

Active Learning Cycles
Model for Improvement
CDPM Framework – Change Concepts
Evidence-based Clinical Practice Guidelines

Infrastructure
“Gateway”
A virtual real-time workspace

Support
QI Coach
QUALITY IMPROVEMENT COACH IN PHC

• Facilitative QI integration & application for primary healthcare teams

• Support in building capability and capacity for sustainable change

• External Coach, geographically located across Ontario

• Scoping of role based on set of core competencies (Can Meds framework) tailored to PHC context
SUPPORTING PRACTICE LEVEL CHANGE FOR SYSTEM-LEVEL IMPACT

Quality Improvement /Clinical Integration Stream

Office Practice Redesign
Diabetes
Integrated Cancer Screening
Hypertension
COPD
Asthma

OPR Intensive Stream

Targeted to Office Practice Redesign: Access and Efficiency

Experience of Care
Population Health
Efficient use of Resources
STRATEGIES FOR SCALING UP

• Partnering to expand the scope and reach of improvement efforts to other models of PHC
  – PHC organizations, Other Healthcare organizations, Other QI organizations

• Leveraging the Ontario Excellent Care for All Act, 2010
  – Focus on Quality, Value and Evidence-based Care

• Demonstrating downstream impact
  – Linking practice level data with administrative data (ICES)
THE CASE FOR QI IN PHC

Advancing Practice Level Changes
- Timely Access to Care
- Chronic Disease Management
- Prevention and Screening
- Panel Management
- Team-Based Care
- Co-ordinated Care Transitions
- Partnerships and Collaboration
- Performance Measurement
- Patient Engagement

For System Level Impact
- Healthier Populations
- Improved Patient and Care Team Experience
- More Efficient Use of Resources
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