



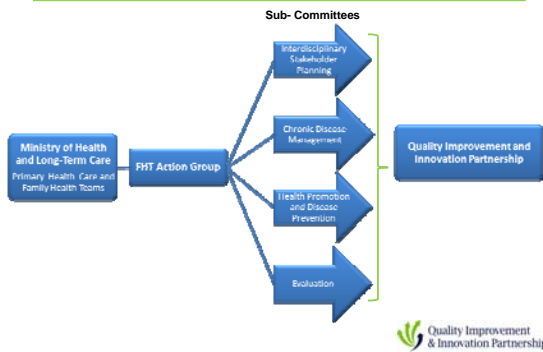
SUPPORTING ONTARIO'S FAMILY HEALTH TEAMS

Mission of FHTs

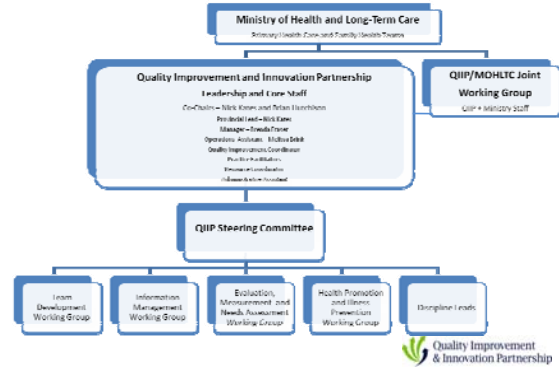
To improve access to **effective, comprehensive patient centred, team-based primary health care** which **supports self-management**, emphasises **health promotion and disease prevention**, and enhances the **management of individuals with chronic diseases** through programs that are **well linked with other local health and community services**.



Formation of QIIP



QIIP Organizational Structure



Three Transition Steps for FHTs

- Foundation tasks
 - HR / Recruitment
 - Organisational frameworks / governance
 - IT
 - Space
 - Community partnerships
- Building teams
- Improving the quality of care that FHTs provide



Improvement and Innovation in Family Health Teams



How QIIP helps FHTs



- Develop networks and links between FHTs
- Provide resources and supports
- Support the introduction of a quality improvement agenda

Introducing Improvement

- Framework
 - Evidence Based Guidelines
 - The Care Model (Ontario CDPM Framework)
 - The Improvement Model (PDSAs)
- Method
 - Learning Collaboratives (Breakthrough Series Methodology)
 - Chronic Disease Management Strategy
 - Preventive Care Strategy
 - Access and Office Efficiency
- Supports
 - Practice Facilitators
 - Leadership Track
 - Knowledge Management Strategy
 - Spread and Sustainability

Learning Collaboratives

QIIP Learning Collaboratives

- 3 Collaboratives (2008 – 2010)
- 14 – 16 month duration
- Opportunity to send team offered to all FHTs
- Up to 50 teams in each collaborative
- Focus on learning the methodology through:
 - Improving diabetes care
 - Screening for colorectal cancer
 - Improving access and efficiency
- First collaborative
 - 35 teams from FHTs
 - 3 teams from CHCs
 - 1 PHC Shared Care Pilot

QIIP Learning Collaboratives

- Supported by Centre for Strategic Innovation (IHI Affiliated Consultants plus Other Partners in QI, CDPM)
- Project Management Team (CSI + QIIP + MOH)
- Collaborative Planning Group
 - Co-Chairs (FHT Lead Physician and FHT ED)
 - Lead Faculty for Diabetes, Colorectal Cancer, Access
 - Stakeholders from FHTs (FPs, NP, Pharmacist, CDM Program Manager)

QIIP Learning Collaborative - Components

- FHT Application Process
- Formation of QI Team to attend Collaborative
- Pre-work
 - Review charter and measures for Collaborative
 - Team composition, roles and team meetings
 - AIM statement
 - Assessing Chronic Illness Care (ACIC)
- Attendance at 3 2-day Learning Sessions + Congress

QIIP Learning Collaborative - Components

- Action periods with rapid testing (PDSAs)
- Change package/ideas linked to components of care model
 - Self-management
 - Delivery system design
 - Decision Support
 - Clinical Information System
 - Community Partnerships
 - Organization of Health Care – Environment for Improvement
- Monthly reporting on common set of measures
- Virtual office for posting/sharing by teams
- Spread and sustainability



Practice Facilitators

- 12 facilitators hired to date – 7.5 FTEs
- Skills in systems / processes
- Regular FHT visits
- Build local capacity
- Ongoing role, but less involved as team matures
- Plus
 - telephone support
 - Email support
 - Conference calls



Reflections from Learning Session

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- As member of Collaborative Planning Group
- As member of participating FHT (Peterborough Networked FHT)



Questions?

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And soon..... www.qiip.ca

