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

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
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 (PDPMs)
- Method
  - Learning Collaboratives (Breakthrough Series Methodology)
  - Chronic Disease Management Strategy
  - Prevention Care Strategy
  - Access and Office Efficiency
- Supports
  - Practice Facilitators
  - Leadership Track
  - Knowledge Management Strategy
  - Spread and Sustainability

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 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

Learning Collaboratives

- Supported by Centre for Strategic Innovation (HHR 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

- 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 1

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

Questions?

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And soon……. www.qiip.ca