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"Here is Edward Bear,coming downstairs now, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think of it"

A.A. Milne 1926

Illustration E.H.Shepard 192614

FHTs were often over-whelmed by all they needed to do

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QIIP's Mandate

Assisting FHTs with

- developing and evaluating programs
- building teams and integrating additional health professionals
- building links with community partners
- improving the ways that care is delivered
- creating organizational frameworks to support these changes

Negotiating the transition to a new model of primary health care

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Like trying to cross a bridge while its still under construction

Improvement and Innovation in Family Health Teams

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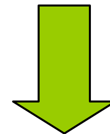
Practice Features of FHTs

» Team-based care
» Population approach
» Quality improvement
» Performance measurement
» Community partnerships
» Patient engagement



Well-functioning team + Strong organizations + High quality care

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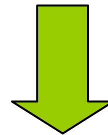

Well-functioning team + Strong organizations + High quality care

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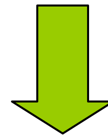

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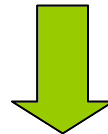

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How QIIP Helps FHTs

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

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Introducing Improvement

- Framework
  - Evidence-Based Guidelines
  - The Care Model
  - The Improvement Model

- Method
  - Learning Collaboratives focusing on:
    - Chronic Disease Management (diabetes)
    - Preventive Care (colorectal cancer screening)
    - Access and Efficiency

- Supports
  - Practice Facilitators
  - Leadership development and capacity building
  - Learning communities

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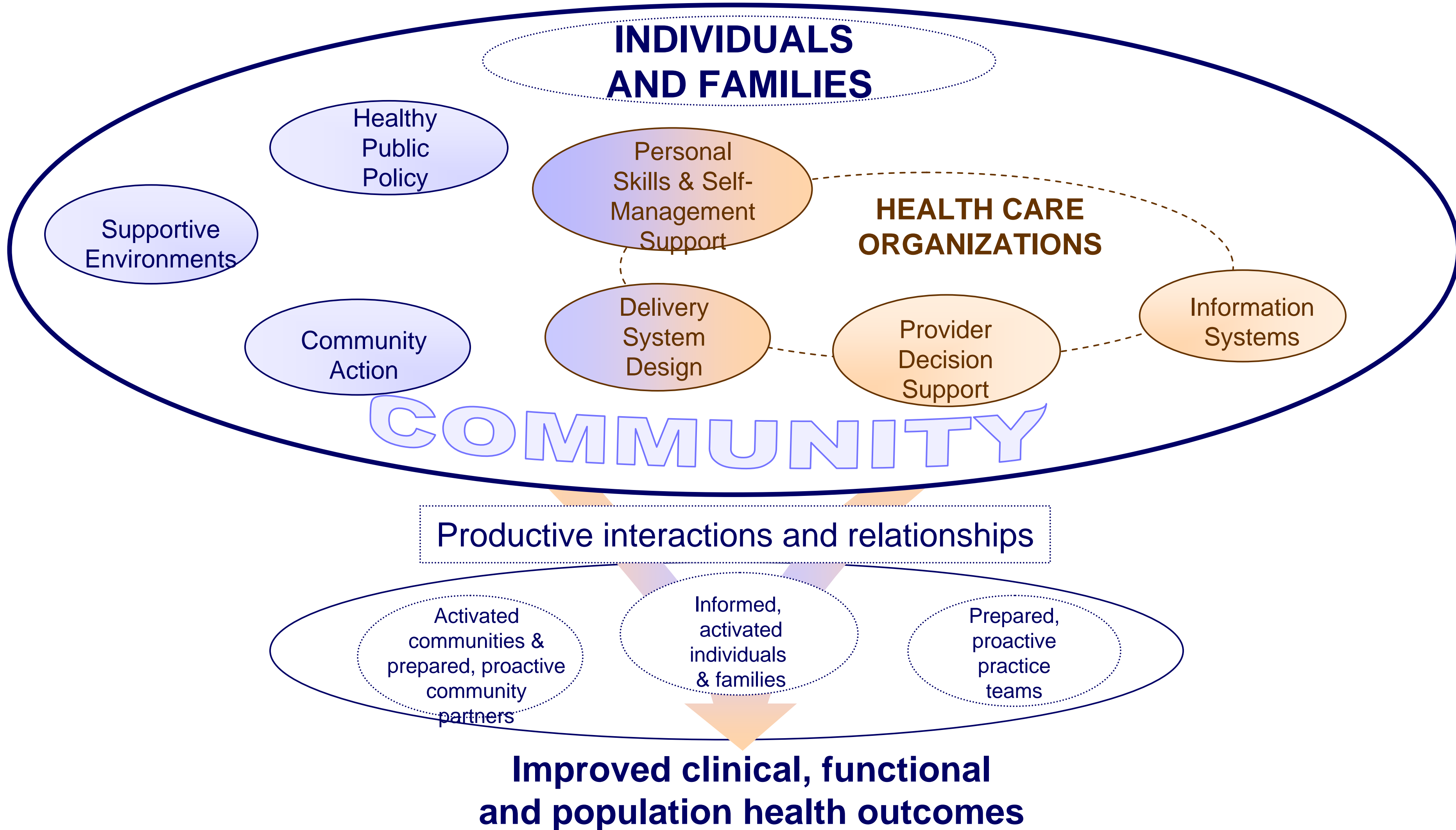
The Care Model

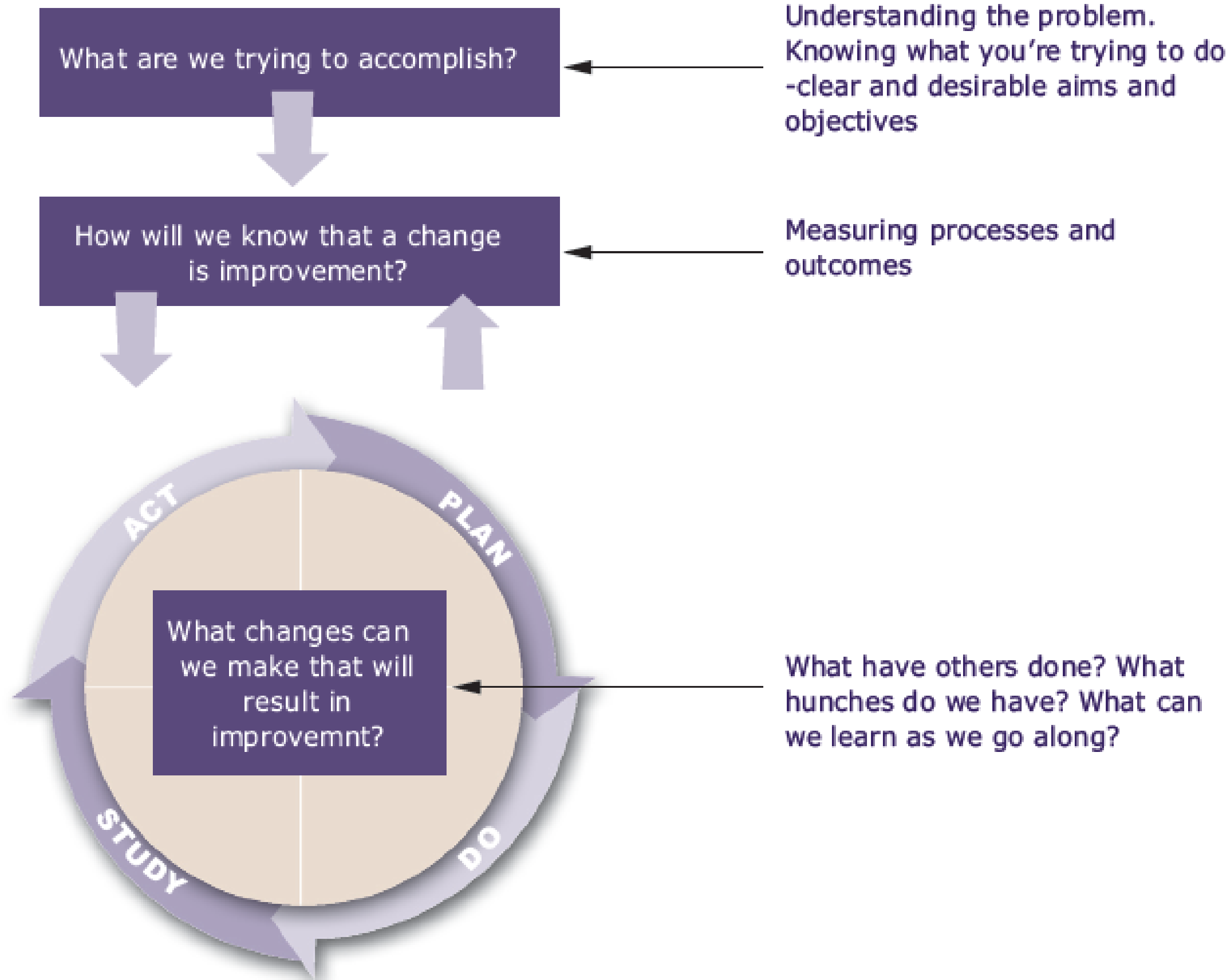
Ontario's CDPM Framework



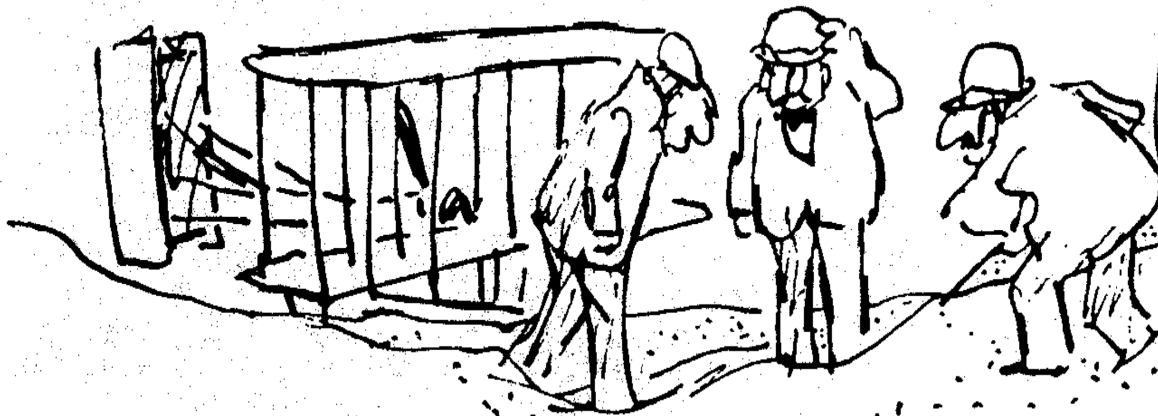
Improved clinical, functional and population health outcomes

The Improvement Model

The improvement model



Immediately after Orville Wright's historic 12-second flight, his luggage could not be located.



Not everything will work out exactly as anticipated

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Possible PDSA's

How many seniors (with elevated BP) have had their BP monitored in last 3 month / received an evidence-based intervention

Call 10 seniors to ask them about their current BP monitoring

Send out 25 letters re CHAP and follow-up with phone calls

Call 10 patients when results received from pharmacy

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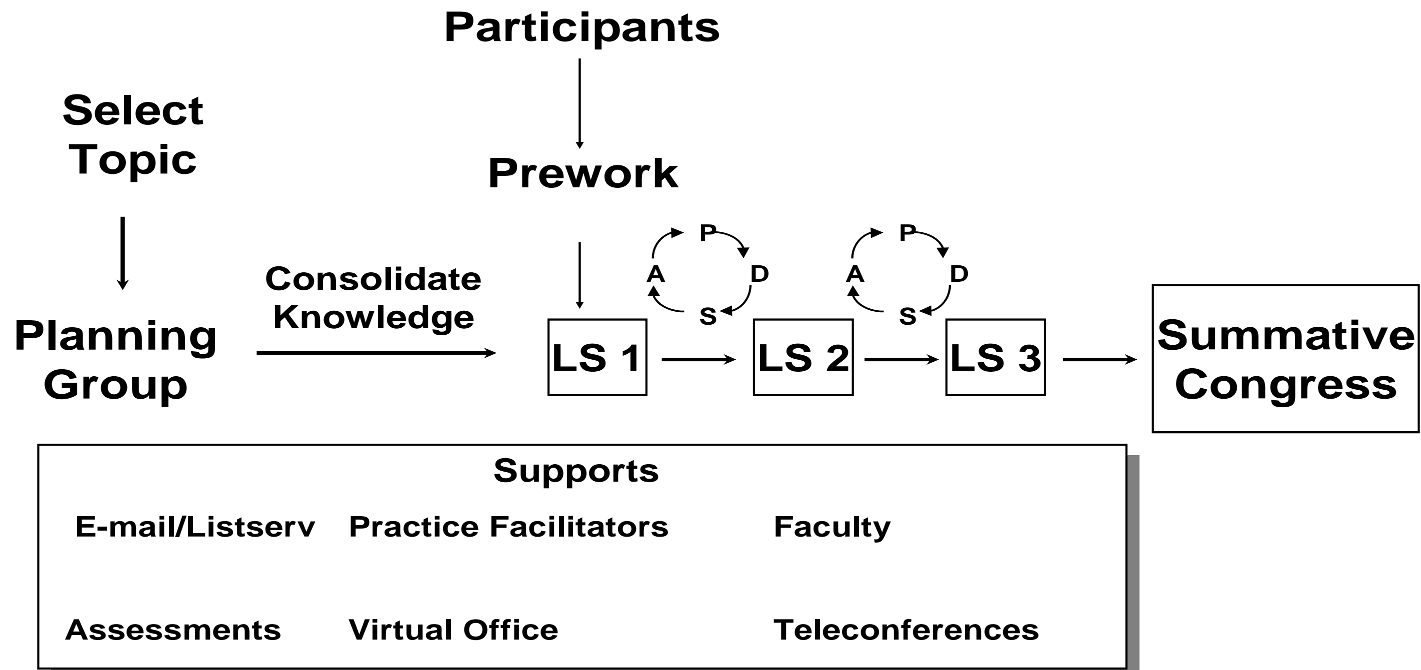
The Learning Model

IHI Breakthrough Series Model



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QIIP Learning Collaboratives

- 3 Collaboratives - 2008 – 2010
- ~ 15 month duration
- Opportunity to send team offered to all FHTs
- Focus on learning the methodology through:
  - Improving diabetes care
  - Screening for colorectal cancer
  - Improving access and efficiency
- First collaborative – held May 26, 27
  - 36 teams from FHTs
  - 3 teams from CHCs
  - 1 PHC Shared Care Pilot
- Second Collaborative – begins November 3, 4/08

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Practice Facilitators

- 16 facilitators hired to date – 11.5 FTEs
- Eventual ratio 10 teams to 1 FTE
- Skills in coaching + team
- Regular FHT visits plus
  - telephone support
  - Email support
  - conference calls
- Build QI readiness and capacity
- Ongoing role, but less involved as team matures

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Specific concepts applicable to CHAP

Leadership within a practice

- Lead team / individual within a practice
- Health Promotion / CHAP

Community Linkages

- List / know of key community resources / partners
- Establish personal contacts with one or two key partners

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Specific concepts applicable to CHAP

Pro-active follow-up

- Disease Management Registry / EMR – Population Health Capability
- Application of Improvement model / PDSA approach
- Pro-active follow-up
- Prepared visits

Self-Management Support

- Goals and plan
- Relevant information (health literacy)

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Information must be presented in an easy to understand format

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Questions?

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