Collaborating for Better Care

The Story of Partnerships for Health, **A SUCCESSFUL QUALITY IMPROVEMENT PROJECT**

Partnerships for Health

A Chronic Disease Prevention and Management Initiative

> There's simply too much at stake, and too much work to do, for a single family physician to be able to cover all the bases.

Dr. David Graham
East Elgin Family Health Team

Support for this work has been provided by the Government of Ontario. Partnerships for Health was sponsored by the South West LHIN and the South West CCAC, who provided oversight of the project. The views and opinions expressed herein do not necessarily represent the official policies of the Government of Ontario.

Welcome to Partnerships for Health

We are passionate about improving health care.

That's why more than 300 primary and community care professionals in 73 practices across South West Ontario participated in this innovative improvement initiative. We worked in inter-disciplinary, cross-organizational teams to develop and test new and better ways to care for people with diabetes.

It wasn't always easy, but it worked! Clinical and process outcomes improved significantly, and patients and professionals were more satisfied with the experience of care.

With this report we share the experiences and results of Partnerships for Health (PFH). We're proud of what we achieved. We hope it will inspire other health professionals to follow in our footsteps and undertake quality improvement projects. We also hope it will inspire other stakeholders to support their efforts.

Our health system must change. It must be better for patients, better for health professionals, sustainable for society as a whole. We know that it can be done.

Yours truly,

The PFH participants

To find out more about the quality improvement process, please visit the South West Local Health Integration Network's (LHIN) Quest for Quality website at www.questforquality.ca.

“PFH was on the ground delivering the improvements in outcomes that had been identified as part of the LHIN strategy for chronic disease and the provincial strategy for diabetes. It was a living laboratory, an opportunity to work with teams and individuals to support real improvements in the care process.”

Kelly Gillis
Senior Director of Planning,
Integration and Community Engagement
South West LHIN

The PFH Story

Chronic disease touches all of us. Almost 80% of Ontarians over the age of 45 have a chronic condition. More than half have two or more. When chronic conditions are not managed well, people often develop other conditions. Chronic disease accounts for more than half of all health care costs in the province.

So what can we do? Work to prevent and manage chronic disease better by having everyone involved working together as teams focussed on improving the client experience and outcome. That was the idea behind Partnerships for Health, an innovative quality improvement initiative launched in the South West LHIN in 2008.

The PFH initiative was funded by the Ministry of Finance's Strengthening our Partnerships program, with the support of the Ministry of Health and Long-Term Care. The project was sponsored by the South West LHIN and the South West Community Care Access Centre (CCAC). A Project Steering committee representing each partner organization provided leadership to the work. A project management team formulated the approach and led the initiative. The Centre for Studies in Family Medicine, Schulich School of Medicine & Dentistry, the University of Western Ontario conducted the external evaluation of PFH.

Four Pillars

The PFH initiative was built on four pillars:

1. **Evidence-based guidelines** from the Canadian Diabetes Association
2. **The CDPM Framework**, an evidence-based approach to improving chronic disease prevention and management in Ontario. It outlines six components the system must address to improve outcomes for patients and reduce health care costs.

Ontario's Chronic Disease Prevention and Management Framework

Improved clinical, functional and population health outcomes

“When you see how easy it is to test a theory in real life on a small scale, it makes the idea of implementing changes to an overall process less threatening. An effective implementation will proceed more naturally after a number of rapid cycles or tests.”

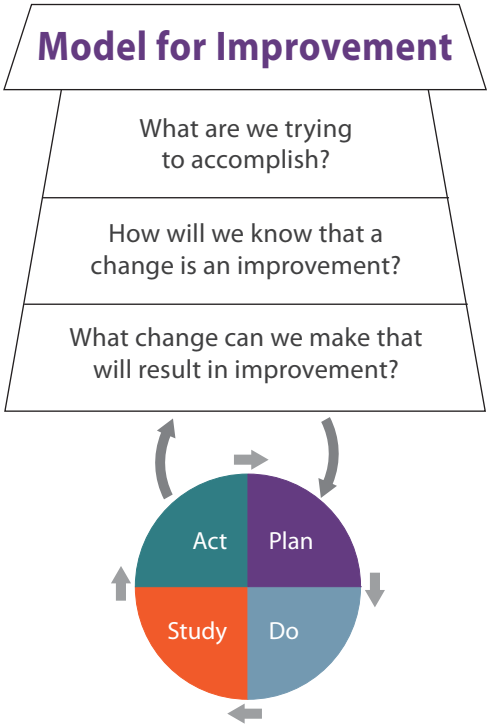
Tom Kontio
Pharmacist and Diabetes Educator
Thames Valley Family Health Team

3 **The Model for Improvement**, a simple yet powerful way to speed up quality improvement changes.

Teams began by addressing three questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in an improvement?

They then used the Plan, Do, Study, Act (PDSA) cycle to make and evaluate small changes.



From: Associates in Process Improvement

4 **The Learning Collaborative model**, an action-oriented learning process that brings health care teams together to focus on a specific gap in care. The PFH teams met for three two-day collaborative learning sessions where they shared information about best practices and compared experiences.

Partnerships for Health was also influenced by the work of the Quality Improvement and Innovation Partnership (QIIP), a provincial organization funded by the Ministry of Health and Long-Term Care. At the time that PFH was launched, the QIIP Collaborative Series was working with Family Health Teams across the province. A member of the PFH Project Management Team served on the QIIP faculty, making it easy for the two initiatives to share content and techniques. The project was also influenced by the findings of the Canadian Home Care Association National Home Care and Primary Care Partnership Project, which highlighted the "essential and definitive role" for home care programs in primary care.

“I started as an outsider at the table. I was invited in, and we talked about our patients and clients from that point on. We built solid relationships and it did improve patient identification and referral to the CCAC, and ultimately, medical management.”

Connie Vandersleen
Case Manager, South West CCAC

What we wanted to do and how we did it

The goal of PFH was to advance chronic disease care by:

- Developing partnerships between family physicians and their primary care teams, and South West CCAC case managers and the broader health community
- Empowering people with diabetes and promoting self-management
- Demonstrating the impact of these interventions on clinical outcomes
- Supporting information management, communication and integration among team members
- Evaluating the effectiveness and impact of the initiative

Here's how we went about it:

- Recruited project participants in three stages. Among the methods used:
  - Written communication by mail and e-mail to all family physicians
  - Letters from LHIN CEO and Ontario College of Family Physicians board president
  - Phone calls
  - Presentations at conferences, staff meetings, dinner meetings, etc.
  - Advertising in targeted and general print media
  - PFH website
- Established integrated teams involving physicians, practice staff, South West CCAC case managers, and other community partners, such as Diabetes Education Programs, pharmacists and optometrists
- Implemented a collaborative learning methodology
- Developed alternate learning methodologies to respond to participant needs
- Measured and monitored key clinical indicators
- Did team development and learning with physicians, practice staff, case managers and other community partners
- Provided practice coaches
- Provided advice and support on information management to deliver population-based care

Timeline

- Early 2008 – PFH launches
- Late May, 2008 – First three teams (Wave 1) meet to start the process. Wave 1 teams mapped the process of diabetes care, identified opportunities for improvement, and did small tests of change
- Fall 2008 – First Learning Collaborative held
- Early 2009 – Nine Wave 2 teams begin work
- Early 2009 – Three practice coaches join the PFH team

“We could see the patients connecting the dots. They began to see the connection between their A1c and their physical activity and diet, and they understood what we’re testing for when we do blood work.”

Heather Barrett
Health Educator
Brockton Area Family Health Team

- Late 2009 – Wave 3 teams begin to work, and over the next six months 61 new teams join PFH. Four learning modalities were made available to these teams — a spread collaborative, knowledge transfer day, web-based learning, and practice-based information sharing
- October 2010 – Outcomes Congress held to celebrate and share the teams' accomplishments
- December 2010 – Spread Collaborative held for 18 teams ready to apply their learnings to other chronic conditions — chronic obstructive pulmonary disease (COPD) and asthma

The Power of Team

The evidence is clear: integrated care teams are essential to delivering great care.

But it's not always easy to work that way. Working across disciplines, organizations and the care spectrum requires careful planning and communication. It also takes a shared commitment to putting the patient at the centre of the team's work.

Through PFH, team members developed a new understanding of the value of teamwork in chronic disease management. They learned the value of population-based care and being accountable for clinical outcomes across the system. They learned to think and work more collaboratively.

PFH sites built interdisciplinary teams that included:

- A primary care physician
- Nurse practitioners
- A South West CCAC case manager

In addition, most teams included:

- A diabetes educator
- Other community providers such as:
  - Pharmacists
  - Social workers
  - Optometrists
  - Chiropodists
  - Mental health workers

Each team reflected the community it served and involved health care providers appropriate to the needs of its population.

“Improvements used to come from the top down, sometimes from people who didn’t understand the frontline clinical experience. With PFH, change happened at the grassroots level by people who knew the clients and could bring improvements into their work days.”

Cathy Babin-Niven, NP
Owen Sound Family Health Team

Working Together

PFH teams worked together in new ways. They:

- Held bi-monthly meetings to review data and plan improvements
- Mapped care processes to identify improvement opportunities
- Identified the low, moderate and high-risk patients in their practices and developed interventions targeted at each sub-population
- Developed and tested new ways to deliver care using the PDSA model and best practice guidelines
- Worked together to deliver planned care at every visit
- Held case conferences
- Conducted "morning huddles" to prepare care for patients with greater need
- Ensured regular follow-up of patients
- Developed algorithms for team interventions, such as referring high-risk and complex patients to the South West CCAC case manager or Diabetes Educator for care management
- Held group visits and diabetes clinic days
- Conducted proactive outreach, including telephone and e-mail interactions with clients
- Clarified and developed a better understanding of each other's roles
- Improved communication among team members
- Built a sense of common purpose in improving diabetes care
- Tracked results using time series run charts

Learning Together

PFH supported the teams with a variety of learning approaches, including:

- Practice coaches who provided expert advice and guidance, and helped teams apply their learning and do tests of change
- Monthly teleconferences that brought teams together for problem-solving, data review, and consultation with expert faculty
- A web-based curriculum with content in text, video and PowerPoint formats, for teams unable to commit to the learning collaborative model
- Refresh sessions to provide an opportunity to reinforce and support the progress of the teams
- The Outcomes Congress, held near the end of the project, to give all participants an opportunity to celebrate their achievements and share learnings
- The spread session, also held near the end of the initiative, to begin the process of spreading learning and change to other chronic conditions

Over the course of the initiative, more than 500 providers attended PFH learning sessions.

“I now feel there’s a team behind me – a team I can call on, whether it’s the pharmacist, or a social worker, or the CCAC case manager. That gives me confidence that I don’t have to sit at home and wonder.”

Yvonne, patient, Happy Valley FHT

Hey Coach!

PFH employed three practice coaches. They:

- Provided in-person, telephone and e-mail support
- Shared information and resources
- Helped with team building
- Supported quality improvement work such as PDSAs
- Supported the reporting process

Collaborating with Patients

On a day-to-day basis, it's individuals who manage their own chronic conditions. PFH recognized that to be successful in managing chronic disease, the health system must partner with patients, helping them to be more knowledgeable and effective managers. It's a relatively new focus for many health professionals.

- Team members were introduced to the "5 As" of self-management support – Assess, Advise, Agree, Assist, Arrange. A sequential series of steps to facilitate patient self-management and behaviour change.
- Team members were encouraged to use the Self-Management Toolkit developed by the South West LHIN [www.selfmanagementtoolkit.ca]
- Patients received education about lab tests and the results were shared with them
- Many teams supported community-based education sessions and some offered them in their own practices through diabetes clinic days or group visits
- CCAC case managers worked closely with patients to identify barriers to self-care and connect them with community resources

Collaborating with Partners

In the past, only about 12% of all referrals to the South West CCAC came from family physicians, usually because of serious complications. Through PFH, case managers became an integral part of each of the 73 teams, attending in person at the team office and taking part in education and improvement sessions. Case managers:

- Moved from process-based to clinical outcomes-based care
- Provided on-site support with primary care teams
- Improved communications (streamlining forms, referral processes, etc.)
- Screened proactively for CCAC services, often in the doctor's office
- Raised awareness of home and community resources
- Attended team meetings and case conferences, helping to conduct reviews of complex patients
- Coordinated insulin starts at home
- Participated in clinic days
- Connected patients to community supports

> Many of our partners thought our only role was delivering home care. We've shown that it's broader than that. We've been able to explore how we can help to support clients as they move through the system, and improve clinical and system outcomes as a result.

Catherine Statton
Partnerships for Health Project Manager
South West CCAC

Diabetes Education Program (DEP) staff members also took on a broader role. Through PFH, they:

- Improved communication (streamlining forms, etc.)
- Attended team meetings and case conferences
- Provided on-site support and participated in clinic days
- Made more referrals to the community and strengthened referral links from hospital to DEP
- Ensured patient education materials were consistent with CCAC and primary care
- Conducted shorter, targeted education sessions based on issues raised by patients

Other community providers – chiropodists, pharmacists, physiotherapists, optometrists, and social workers – were also integrated into the care process.

The Power of Information

You can't improve what you don't measure. PFH recognized that health care teams must be able to track their results to know what changes are working and what aren't. PFH teams were supported to use their existing technology better and to learn more about the power of information management. There were many challenges but teams embraced technology and worked to optimize its use.

Information Management Support

PFH provided the teams with the following:

- Information management coaching and support
- A website to build public awareness, serve as a hub for reference materials, and a location for posting clinical results, and helping teams share information and ideas
- Help with data exchange among care providers, including Diabetes Educational Programs, CCAC case managers, hospitals and primary practices
- Education and training on the management of patient information, and the use of electronic medical record systems and other software to track population care and outcomes

“PFH was a transformative experience for everyone involved. It reinforced our commitment to working in partnership with providers across the health spectrum, and will change the way chronic disease management is done across South West Ontario and beyond.”

Sandra Coleman, CEO
South West CCAC

With the help of PFH faculty experts and the eHealth Lead, PFH teams:

- Mapped their care processes and uncovered improvement opportunities, such as:
  - Reminder calls to no-show patients
  - "Labs before appointments" policy
  - Diabetic flow sheet
  - Referral program for pre-diabetics

- Learned the importance of data discipline – using a consistent location, terminology and format for capturing information
- Received training in the use of Microsoft Excel, PowerPoint and Outlook
- Received training on how to populate the PFH tracking and graphing system
- Learned how to make optimal use of thehealthline.ca for community information and referrals

PFH also supported the South West CCAC to enhance the use of existing technology to review data, share information with team members, and generate reports. For example, a process was created for identifying patients shared by the CCAC, the family practice and other team members. Several primary practices created electronic referral forms that could be transmitted directly from the EMR electronic system to the CCAC. And the CCAC was able to share information from its electronic system with the primary practices.

Several Diabetes Education Programs also received information management coaching and funding to make the best use of their current IT systems.

Indicators tracked by PFH Teams

Percentage of patients :

- With blood sugar (glycated haemoglobin or A1c) at less than 7
- With Blood Pressure (BP) less than 130/80
- With Low-Density Lipoprotein (LDL) cholesterol at less than 2.0 millimoles
- With documented self-management goals
- With an A1c (blood sugar test) taken within six months
- On Angiotensin Converting Enzyme (ACE) and/or Angiotensin Receptor Blockers (ARB drugs) - blood pressure medications
- Using tobacco
- Receiving
  - Depression screening
  - Annual eye exam
  - Annual foot exam
  - Renal screening to test for kidney health
  - Flu vaccine
  - Pneumococcal vaccine to prevent pneumonia
  - Annual dental exam

“Partnerships for Health was a lot of work, but it was worth it. I hope the improvements we’ve made will be shared with other physicians, so that they can be diligent in treating their patients with diabetes and helping prevent complications in the future.”

Marilyn Bowman
Diabetes Educator, Listowel

What we achieved

- Can we change the health system to make care better for patients with chronic illness?
- Can professionals from different sectors work together in effective teams?
- Can patients be empowered to care for their own chronic conditions?
- Can technology be used to support integration?
- Does integrated care really make a difference?

Yes, yes, yes, yes and yes!

PFH showed that quality improvement can work. Collaboration, partnership, innovation, and a willingness to embrace new ideas and approaches produced stellar results.

The Center for Studies in Family Medicine at the University of Western Ontario undertook a formal external evaluation of the initiative. The evaluation team looked at both process and clinical outcomes, using qualitative and quantitative data from before and after the initiative.

Here are some of the results:

Patient Care

- The percentage of Wave I and II patients with blood pressure and LDL cholesterol at the guideline target increased significantly
- The percentage of patients who received foot exams, retinal exams, BMI, and depression screening increased significantly
- The percentage of patients with documented self-management goals increased significantly
- The percentage of patients who quit smoking increased significantly in Waves I and II
- The percentage of patients who were prescribed an ACE or ARB increased significantly
- Patients felt that:
  - They were treated as a whole person, not just a "diabetic"
  - Their knowledge of diabetes increased significantly
  - They were more confident about managing their diabetes between appointments
  - Their self-care was better
  - They were more satisfied with the care from other providers, and the collaboration among providers
  - They had a better quality of life

Collaboration

- The CCAC moved from a reactive to a proactive approach
- The CCAC role was better understood by all partners
- Access and referrals to CCAC case managers increased significantly

> There wasn't much support. It was, 'you have diabetes, here's your medication, now go home.' Now it's much different, especially in this clinic. Everybody cares for you.

Donna, patient, Sauble FHT

- Case managers did patient assessments in primary care offices and in homes to help prevent institutionalization
- Providers reported that they felt more confident in taking care of patients with diabetes
- Team interaction and capacity increased significantly
- Delivery of evidence-based care, follow-up and patient education increased significantly
- Communication, collaboration and care planning with providers increased significantly
- Screening and early identification improved
- Provider satisfaction improved
- 100% of physicians felt that having a case manager as part of the team enhanced patient care
- CCAC found that their clients with diabetes had fewer hospital and emergency room visits
- NPs, RNs, RPNs and front office staff conducted preventive care assessments and other care processes
- Pharmacists engaged in medical reconciliation and support for medication adherence
- Social workers conducted depression screens and coordinated with primary care
- Physicians felt better able to focus on clinical management and treatment planning

Despite good progress in building collaborative care processes, some teams noted concerns with:

- Shared decision-making
- Cooperation, coordination and partnership
- Support from senior leaders
- Commitment of financial and other resources

Information technology

Providers felt that they were more proficient in using the EMR and that it:

- Was easier to use
- Was accurate, complete and relevant
- Enhanced the team's ability to share information and coordinate care
- Helped make improvements in clinical care

Economic value

A thorough economic evaluation was conducted. The researchers found that the PFH population was relatively healthy when the project began. The analysis suggested that targeting a less well controlled population would result in better long-term cost benefits. Researchers also noted that cost effectiveness could be improved by using existing programs and services.

“I think it’s wonderful that health providers are coming together to better integrate our health care system to improve the patient experience and the quality of care for people living with diabetes.”

Deb Matthews
Minister of Health and Long-Term Care

What we learned

Why was PFH so successful? Here are some of the key factors:

- Strong organizational leadership within partner organizations
- Strong physician leadership within the primary care practices
- Creation of integrated teams of health care providers, including CCAC case managers, DEP personnel and community partners
- Strong quality improvement infrastructure coordinated on a regional level
- Formal learning opportunities for the integrated teams based on the Learning Collaborative model
- Stipends and Continuing Medical Education (CME) credits for family physicians
- Practice Coaches to support and strengthen teams
- A strong emphasis on self-care
- A system of planned, proactive, population-based care that put the patient at the centre
- A shared understanding of roles among partners
- Evidence-based practice guidelines built into daily practice
- A commitment to quality improvement
- Improved communication and information sharing among team members using IT
- Enhanced ability to manage data and use EMRs
- Accountability for clinical outcomes

A new model

PFH participants explored how to shift the approach to care from one that is reactive and focused on cure, to one that is proactive and focused on supporting individuals to live well with their conditions. The model that emerged included:

- An expanded role for the CCAC to support proactive interventions
- The development of integrated teams
- The establishment of care algorithms that lay out roles and responsibilities based on patient needs
- The use of information technology beyond individual care planning
- Ongoing collection of clinical and process measures
- Provider support for patient self-management
- The flexibility to respond to conditions and preferences in each community, and a commitment to ongoing testing of changes to improve quality

“I now feel that I have my diabetes under control, whereas before I felt that my diabetes controlled me. It’s a great thing.”

Fred, patient, Sauble FHT

Next steps

What are the next steps for quality improvement in our region?

- Further develop the quality improvement infrastructure to include collaborative education and reporting on indicators
- Imbed quality improvement discussions in routine practice meetings
- Continue to promote an understanding of self-management support
- Promote re-design strategies for clinical practices in primary care and across partnering organizations
- Broaden the system of care coordination to smooth transitions and better support complex patients
- Make IT support a part of future quality improvement initiatives
- Continue to create integrated care teams including CCAC case managers
- Encourage quality improvement as an essential part of any primary care practice
- Keep using practice coaches to support quality improvement

The Partnerships for Health project is over, but the work is really just beginning.

Quality improvement isn't easy. It takes all of us working together to make real change. It means letting go of familiar ways of working and embracing new ones. It means recognizing the expertise of others. It means breaking down silos, sharing information, learning new skills.

And it's worth it. PFH showed that we can make a difference. We can improve and prolong lives. We can wrap care around our patients, so they feel comfortable and confident. We can help ensure that our health system is sustainable in the future. We can rediscover the joy of delivering exceptional care, day in and day out.

Diabetes is one chronic disease. Now it's time to take the learnings from PFH and other similar projects, share them with others, and apply them to other chronic conditions. There's work ahead … let's get on with it!

Partnerships for Health

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www.partnershipsforhealth.ca