BACKGROUND

Over the last decade Ontario has made significant investments to transform the organization and delivery of primary healthcare to improve quality and access. One of these included the establishment of Family Health Teams (FHTs). \(^{(1)}\) In 2007, the Ontario Ministry of Health and Long Term Care (MOHLTC) established the Quality Improvement and Innovation Partnership (QIIP), now integrated within Health Quality Ontario (HQO). The role of the QIIP was to support primary healthcare (PHC) teams to develop strong inter-professional care teams, improve collaboration with community care providers, and build capacity to improve the management of chronic diseases, illness prevention and access to care.

During 2008-2010, the QIIP launched three waves of Learning Collaboratives (Figure 1) and invited all Ontario PHC teams to participate. Each wave lasted 14-16 months, with a focus on quality improvement (QI) methods, team work, management of diabetes, colorectal screening and advanced access to care.

OBJECTIVES

(1) Evaluate the fidelity of implementation of the QIIP Learning Collaboratives to its intended plans,
(2) Identify and assess modifications and adjustment made to the program in the process of implementation,
(3) Describe capacity building of the QIIP organization in the process of implementing the QIIP Learning Collaboratives.

METHOD & MEASURES

A Logic Model was developed to display the planned activities and outputs of the initiative. This logic model was used to guide the APOE in:
- documenting the intended plans and actual activities
- comparing the programs plans and outputs
- assessing the implementation process using program artifacts & interview data.

Measures

- Program roll-out timeline
- Number of participating PHC teams & attendance in each Collaborative
- Topics of QI presented at each Learning Collaborative
- Changes made to the program during its implementation

RESULTS

(1) Assessment of program documents and implementation evidence showed a high fidelity of implementation to program plans in terms of roll-out time line, recruitment of PHC teams for participation and attendance. (Tables 1-2)

(2) Based on the lessons learned during implementation, modifications were made to the program including using local experts in educational activities, adjusting educational topics and modifying learning materials according to participants’ needs. (Table 3)

(3) Participating teams and the QIIP organization built capacity during implementation process and made Learning Collaborative local to Ontario context.

CONCLUSIONS

The APOE described the planned activities and outcomes of the QIIP Learning Collaborative program and compared these with the actual activities and outcomes that took place. It provided a comprehensive description of a provincial QI initiative in terms of program planning, implementation and intended outcomes. The results and documented lessons-learnt have implications for ongoing QI initiatives in Ontario and for future QI programs in other PHC contexts.

References: