Assessment Oriented Process Evaluation of Health Quality Ontario Learning Collaboratives

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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.

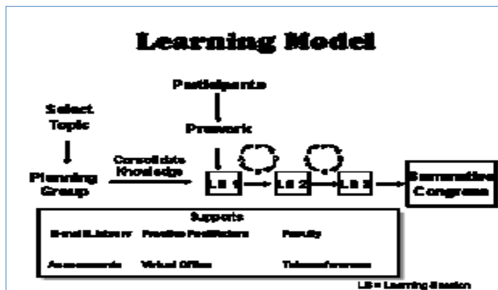

Figure 1: Learning Model

In 2010, a comprehensive mixed-method evaluation was conducted by Queen's University and Western University to examine the effectiveness of the QIIP Learning Collaborative initiative. As part of the evaluation, an assessment oriented process evaluation (AOPE) was performed to evaluate and assess the process of implementation of the Learning Collaboratives.

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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 & MEASUERES

AOPE "is to conceive of the quality of a program's components as a congruency between stakeholders' intentions for the program (their program plan) and the facts of the program's actual implementation." [2, p. 160]

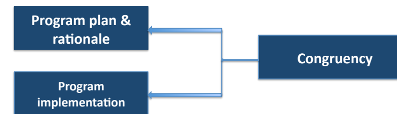

Figure 2: AOPE Model

A **Logic Model** was developed to display the planned activities and outputs of the initiative. This logic model was used to guide the AOPE 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)

Table 1: Program Roll-Out Timelines

Waves		Pre-Work Phrase	Learning Session 1	Learning Session 2	Learning Session 3	Congress
Learning Collaborative 1		Apr. 17-May 23,2008	May 26-27, 2008	Sept. 25-26, 2008	May 7-8, 2009	Sept. 30, 2009
	Action Periods		May-September 08		September 08-May 09	May-September 09
Learning Collaborative 2		Oct. 1-31, 2008	Nov. 3-4, 2008	Feb. 12-13, 2009	Oct. 1-2, 2009	Jan. 25, 2010
	Action Periods		November 08-Febuary 09		February-October 09	October 09-January 10
Learning Collaborative 3		Feb. 19-Mar.12, 2009	Mar. 26-27, 2009	Jun. 22-23, 2009	Jan. 26-27, 2010	May 10, 2010
	Action Periods		March-June 09		June 09-January 10	January-May 10

Table 2: Attendance of Teams and Participants to Learning Collaboratives

Attendance	Collaborative 1		Collaborative 2		Collaborative 3	
	Participants	Teams	Participants	Teams	Participants	Teams
Learning Session 1	239	39	225	39	290	59
Learning Session 2	224	35	250	37	315	55
Learning Session 3	236	35	249	36	324	52
Congress	241	33	204	28	276	49
Average individual attendance	235	34	232	31	301	49

(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)

Table 3: Topics Presented and Ratio of External/Internal Expert Speakers in 3 Waves of Learning Collaboratives

	Learning Session 1		Learning Session 2		Learning Session 3	
Number of topics	18-20		16-18		7-9	
Presented by Speakers	External	Internal	External	Internal	External	Internal
Collaborative 1	15/18(83%)	3/18(17%)	13/18(72%)	5/18(28%)	5/9(56%)	4/9(44%)
Collaborative 2	17/20(85%)	3/20(15%)	9/17(53%)	8/17(47%)	3/7(43%)	4/7(57%)
Collaborative 3	11/20(55%)	9/20(45%)	6/16(38%)	10/16(62%)	2/7(29%)	5/7(71%)

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

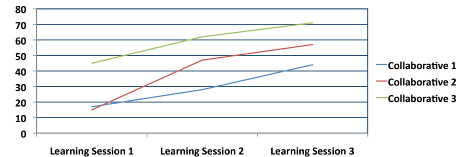

Figure 3: Increase of internal/local expert speakers during progress of the program

CONCLUSIONS

The AOPE 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:

1. Hutchison, B., Levesque, J.-F., Strumpf, E. and Coyle, N. (2011), Primary Health Care in Canada: Systems in Motion. *Milbank Quarterly*, 89: 256–288.
2. Chen, H. T. (2005). *Practical program evaluation: Assessing and improving planning, implementation, and effectiveness*. Thousand Oaks, CA: Sage.