“Collaboration is Innovation”: Using collaboratives to achieve better care, better health and better value in Canada

Stephen Samis, Vice-President, Programs, CFHI

Agency for Clinical Innovation, Sydney Australia
June 10, 2015,
Overview

1. Canadian Healthcare
2. How is Canada doing? Room for Improvement!
3. CFHI: Who we are? What we do? Why is it important?
4. Using collaboratives to spread innovation and drive change
5. Results to date
6. Lessons Learned
7. Discussion
Healthcare in Canada: A legacy of the Constitution

• There is no “national” health system in Canada
• 13 health systems – 1 for each province and territory
• Federal government:
  – provider of healthcare to 750,000 First Nations and Inuit peoples
  – direct provider on reserves and isolated locations
  – Responsible for Veterans and Military personnel
In general, how much ATTENTION do you personally usually pay to the following issues?

Source: 2011 Canadian Election Study (N=4290)
Exhibit 1. International Comparison of Spending on Health, 1980–2010

Average spending on health per capita ($US PPP)

Total health expenditures as percent of GDP

Notes: PPP = purchasing power parity; GDP = gross domestic product.
Source: Commonwealth Fund, based on OECD Health Data 2012.
Public Sector Health Expenditure per Capita in Constant 2010 Dollars

Source: Canadian Institute for Health Information (calculations made by the authors)
How are we doing?

<table>
<thead>
<tr>
<th>Country Rankings</th>
<th>1.00–2.66</th>
<th>2.67–4.33</th>
<th>4.34–6.00</th>
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</thead>
<tbody>
<tr>
<td>Overall Ranking (2007)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>3.5</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Canada</td>
<td>4</td>
<td>6</td>
<td>2.5</td>
</tr>
<tr>
<td>Germany</td>
<td>5</td>
<td>6</td>
<td>3</td>
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<tr>
<td>New Zealand</td>
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<tr>
<td>United Kingdom</td>
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<td></td>
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<tr>
<td>United States</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Care</td>
<td>4</td>
<td>6</td>
<td>2.5</td>
</tr>
<tr>
<td>Right Care</td>
<td>5</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Safe Care</td>
<td>4</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>3</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Patient-Centered Care</td>
<td>3</td>
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<tr>
<td>Access</td>
<td>3</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Efficiency</td>
<td>4</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Equity</td>
<td>2</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Healthy Lives</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Health Expenditures per Capita, 2004</td>
<td>$2,876*</td>
<td>$3,165</td>
<td>$3,005*</td>
</tr>
</tbody>
</table>
## Commonwealth Fund Survey results (2013)

<table>
<thead>
<tr>
<th>Issue</th>
<th>CDA</th>
<th>AUS</th>
<th>UK</th>
<th>USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to get same next day appointment when sick</td>
<td>45%</td>
<td>65%</td>
<td>70%</td>
<td>57%</td>
</tr>
<tr>
<td>Very/Somewhat difficult getting care after hours</td>
<td>65%</td>
<td>59%</td>
<td>38%</td>
<td>63%</td>
</tr>
<tr>
<td>Waited 2 months or more for specialist appointment</td>
<td>41%</td>
<td>28%</td>
<td>19%</td>
<td>9%</td>
</tr>
<tr>
<td>Waited 4 months or more for elective surgery</td>
<td>25%</td>
<td>18%</td>
<td>21%</td>
<td>7%</td>
</tr>
<tr>
<td>Experienced access barrier because of cost in past year</td>
<td>15%</td>
<td>22%</td>
<td>5%</td>
<td>33%</td>
</tr>
<tr>
<td>Exp. gaps in hospital discharge planning in past 2 yrs</td>
<td>50%</td>
<td>55%</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Used emergency department in the past 2 years</td>
<td>41%</td>
<td>22%</td>
<td>27%</td>
<td>39* /48%</td>
</tr>
<tr>
<td>System works well; minor changes needed</td>
<td>38%</td>
<td>24%</td>
<td>62%</td>
<td>29%</td>
</tr>
</tbody>
</table>

* US Insured (v US uninsured)
Our Mission

To accelerate healthcare improvement for Canadians

*We identify proven innovations and accelerate their spread across Canada by supporting healthcare organizations to adapt, implement and measure improvements in patient care, health and value for money.*
CFHI Overview

- Not-for-profit funded by the federal govt
- National organization working directly with health regions, hospitals/orgs, providers
- Support healthcare delivery innovation
- Implement, evaluate & spread new ways of working that provide better care, better health, better value
- Lead collaborations across jurisdictions
What we do...

- Build leadership and skill capacity
- Enable patient, family and community engagement
- Create collaboratives to spread evidence-informed improvement
- Apply improvement methods

CFHI
Accelerating Healthcare Improvement

799 Healthcare leaders

141 Improvement teams

10 Collaborations

2 EXTRA cohorts

CFHI (2014) Annual Report
4 Collaboratives

1. **Geographic Collaboratives (2)**
   - Atlantic Healthcare Collaboration
   - Northern and Remote Collaboration

2. **Spreading Innovations Collaboratives (2)**
   - INSPIRED approach to COPD care
   - Appropriate Prescribing of Anti-psychotic medications in long term care

3. **Partnering with patients and families for QI (1)**
Collaboratives: Start with Why

Why = The Purpose
Pick the right problem

How: The Process
Organize, program, adopt and adapt

What = The Result
Involve the right people
Plan for the necessary resources
Measure the impacts

Adapted from: Simon Sinek (2011) “Start with Why”
CFHI Support

- **Training**
  - Develop and deliver a core curriculum including interactive webinars and face-to-face workshops, includes stakeholder engagement, measurement, change management, etc.

- **Resources**
  - Provide improvement tools and methods and small funding (up to $50K per team in Collaboratives)

- **Coaching**
  - Work with content and improvement experts who co-lead webinar and workshop sessions, review team reports and data and provide 1:1 coaching to teams

- **Cross-team sharing**
  - Maintain an online learning community
  - Facilitate peer exchange
• Develop a patient- and family-centered approach to chronic disease management across 4 Atlantic provinces
• Promote the sustainability of the health system
• Help build a network of regional teams
• Share evidence informed, effective, sustainable and systems-level solutions
• Work together implement improvement projects over 2 years (2012-2014)
“Chronic disease is Canada’s most prominent healthcare problem, costing more than $80 billion each year and causing increased use of emergency departments, extended hospital stays, reduced quality of life and increased mortality rates.”
Percent of population (%) living with chronic disease or risk factor (2012)

Overweight or obese: Canada 51%, Atlantic 59%
Diabetes: Canada 6%, Atlantic 7%
High blood pressure: Canada 17%, Atlantic 19%
Current smoker; daily: Canada 15%, Atlantic 16%
Heavy drinking: Canada 17%, Atlantic 19%

THE BEST THING YOU CAN DO IS GIVE UP SMOKING, DRINKING AND FRIED FOOD

WHAT'S THE SECOND BEST?
AHC: 11 Teams Across 4 Provinces

Newfoundland & Labrador

Prince Edward Island

New Brunswick

Nova Scotia

By disease condition:
- Multi-morbidity
- Diabetes
- Mental Health
- COPD

By priority:
- Self-management
- Delivery sys design
- Decision support
- Community action

*Based on elements of the Chronic Care Model
Results

Competencies Applied (11 teams)

- Assess: All teams
- Design: 10/11 teams
- Implement: 4/11 teams
- Evaluate: 4/11 teams

Verma, Denis et al. (forthcoming) Healthcare Papers
Central Health (NL)
Redesigned an asthma outpatient clinic into a Respiratory Ambulatory Care Centre
New standing orders and improved care pathways provide standardized and evidence-informed care

60 Patients in just 2 months

New COPD outreach program uses telehealth and home-based support to provide:
- self-management education
- action plan development
- psychosocial support
- advance care planning

Western Health (NL)
Implemented:
- Depression-screening tool for people living with type 2 diabetes
- Physician, team and staff self-management education

Patient’s Report:
- Convenient appointments
- Helpful diabetes management plans and education sessions
- Confidence in diabetes self-management

PEI Health
Current:
101 healthcare providers completed self-management training

In 3 years:
1,000+ healthcare providers will be trained

Providers report greater confidence in their self-management ability and likelihood to implement self-management.

Horizon Health Network (NB)
Youth Report Improvement In:
- mental health
- work
- relationships
- money

Decrease in:
- Emergency room visits
- Hospital admissions for a mental health diagnosis
- Use of community mental health services
Social Network Analysis: Pre-Collab

Density: **0.229**

Number of Ties: **116**

Average Degree: **5.403**
Social Network Analysis: Post-Collab

Density: 0.536
Number of Ties: 271
Average Degree: 11.783
“INSPIRED” Collaborative

Implementing a Novel and Supportive Program of Individualized care (for people with) Respiratory Disease

An Outreach Program for Patients and Families living with Advanced Chronic Obstructive Pulmonary Disease
Hospitalization rates are 60% higher in rural areas

Health Indicators. 2008. Canadian Institute for Health Information. Pg. 2
Care Experience for Ontarians Living With COPD

Adapted from: Canadian Lung Association (2005).
Chronic Obstructive Pulmonary Disease (COPD): A National Report Card.
The road to acute care...

Arrive ER in crisis
Long Length of stay

Discharged back to broken system
Off the radar

Poor knowledge of disease; little to no support

Don’t want to burden others

Symptoms worsen (denial, panic) and no plan in place
A recurrent problem . . .

Meet Frank

- 79-year-old widower
- COPD, CHF, Diabetes
- Anxious, breathless, can’t manage
- Often dials 911 & visits the ED
- Hospitalized 7 times over last year
- Keeps a packed suitcase by his chair

What Frank Needs

At home...
With a number to call...

- Case management
- Action plan
- Smoking cessation
- Pulmonary rehab
- Advance care planning
- Self-management support

Self-management support

33
COPD at the QEII HSC

- 300 admissions/year
- Average length of stay = 10 days
- Daily cost to system per day = $1000.00

300 pts x 10 days x $1000.00

= $3,000,000 per year

New Patient and Caregiver Journey

- Admitted to QEII
- Contacted by INSPIRED coordinator early
- Clinical f/u from INSPIRED (home visits/calls)
- Existing primary care services and programs (coordinate)
- Discharged (if possible a ↓ LOS) early post-discharge f/u
3. Cost of Care

60% fewer ER visits and 63% fewer hospital admissions

62% fewer days in hospital

Estimated indirect cost ‘saving’ of $977,000

A collaborative solution to a chronic care problem...

Solution: INSPIRED Approaches to COPD: Improving Care and Creating Value

19 teams → 214 healthcare professionals across 10 provinces

REPRESENTING:

78 Healthcare Sites
INSPIRED Objectives/Measures

• **Improve self-management and care planning** via education, provision of action plans, facilitation of ACP, psychosocial/spiritual support, and liaison with supportive health and community services/professionals for patients with AECOPD who live outside of Halifax and surrounding area.

• **Improve patients’ health-related QoL** Chronic Respiratory Questionnaire (CRQ), Hospital Anxiety and Depressions Scale (HADS), and the Herth Hope Index (HHI).

• **Reduce ER visits and admissions for AECOPD** Record use of acute care services (LOS) both 1 year pre- and 1 year post-program enrollment.
Early Results (one team)

- The Ottawa Hospital: Goal to enroll 100 patients in 12 months. 70 patients in 8 months and 80% reduction in 30 day re-admits
- 6-10 new patients per week with 1.4 FTE
- Certified Diabetes Educators and respiratory educators on self-management and care in home skills
- Commitment from senior leadership
- 10 of 19 teams have enrolled 206 patients (10-70)
- Peer team to team learning - successes/challenges
Reducing Antipsychotic Medication Use in Long Term Care:

Spread Collaborative
Improving the Care of Canada’s LTC residents

One in three LTC residents in Canada takes antipsychotic medications without diagnosis of psychosis.

Antipsychotic medications are not very effective for managing many of the behaviours they are targeting.

Direct communication with staff has been reported to take up only 2% of a resident’s day.
Where we started
....a general acceptance of antipsychotic medication use

A Band Aid Solution

Problem Behaviours
Staff and families request for medications and Antipsychotics prescribed for PRN use

A Difficult Cycle to Break

Residents become:
Withdrown
Sleepy
“taken off their feet”
Problem behaviours increase

More Medications
Why it matters: Meet Vincent

- Vincent was admitted to Trinity Village long term care centre from the neurobehavioural unit where he had been for 3 years.

- He had a history of aggressive behaviour following post operative delirium.

- He was on Seroquel twice daily and prn Haldol, which he was getting regularly according to family.

- On admission, the care team stopped his prn medication based on their assessment and within 1 month had discontinued his Seroquel.

- Vincent’s family described him as “zombie-like” before and now he wanders around the secured unit and interacts regularly with staff.

- They wish this had been achieved years ago.
A pan-Canadian Collaborative Solution to Reducing Antipsychotic Use in Long Term Care (LTC)

15 Organizations

7 Provinces

1 Territory

56 LTC Facilities involved in the first wave of spread

179 LTC homes involved in the second and successive waves of spread

Spreading an Approach from CFHI’s EXTRA Program for Healthcare Improvement

Improving the lives of patients at personal care homes in Winnipeg and beyond

Innovative approach finds major savings

The Problem

For years, healthcare providers at the Winnipeg Regional Health Authority (WRHA) have collected data to assess the needs of elderly men and women who reside at the organization’s 56 personal care homes. The data—known as Minimum Data Set (MDS) and Resident Assessment Instrument (RAI)—are compiled four times a year. The improvement team investigated whether this data could be used to help front-line providers improve care for residents and reduce costs for the WRHA.

The Solution

Joe Puchnick and Cynthia Sinclair—Managers with the WRHA Personal Care Home Program—focused their EXTRA improvement project on determining if this data could reveal insights on the use of antipsychotic medication to treat residents for dementia. More specifically, they sought to uncover whether the use of such drugs could be reduced without inducing adverse changes in residents’ behaviour. With the support of Arlene Wilgoren, CEO of the WRHA, the project achieved success beyond the team’s expectations.

The Impact

Puchnick and Sinclair discovered that facilities where residents with dementia reported markedly lower use of antipsychotic drugs, relied on the TBIH: Physical, Intellectual, Emotional, Capabilities, Environment, and Social care model or PI.E.C.E.S. The PI.E.C.E.S. approach encourages staff to treat patients by looking at not only their health files, but also their personal histories, such as their former careers.

During the six-month improvement project, of the 70 residents already on antipsychotic medications, 25 percent (17 patients) were taken off of their medication. This translates to a 25 percent reduction of antipsychotic medications for the total resident population. This was also achieved without causing any increase in behavioural symptoms or rise in the use of physical restraints.

“it was a pleasure to help lead a project that resulted in improved quality of life for residents, and reduced financial cost to the healthcare system.”
—Joe Puchnick
Manager, Client Affairs – Alberta Canadian Institute for Health Information

Decreasing the overall use of these drugs at the pilot site has enabled it to save $10,000. Given these impressive results, Puchnick and Sinclair put a business plan forward to expand the improvement to the remaining 30 personal care homes in the Winnipeg Regional Health Authority.

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Reducing antipsychotic use in residents without a diagnosis of psychosis

Baseline (target cohort) - End of Quarter 1
(N=535 residents)

- Antipsychotics discontinued: 57%
- Antipsychotic dose reduced: 15%
- Death or transfer: 12%
- Antipsychotics still prescribed: 16%
Changes in team effectiveness over time
Experience of the a) staff and b) patients in coming together
Changes in capacity to execute QI projects
Changes on the IHI Collaborative assessment scale over time (CFHI will provide this scale)
Changes in improvement project quality measures over time (e.g. patient experience, coordination, access, safety, appropriateness, staff satisfaction, efficiency)
Changes in the team and organization use of patient experience and satisfaction information
Plan to create new patient and family forums (e.g. advisory councils, forums, embedded on committees etc).
Changes to organization practices/processes (e.g. development of informational or educational resources; informing policy/planning initiatives; improved care or service delivery, improved organizational governance)
Changes to leadership perspective and support for partnering with patients and families for QI
Additional Indicators

- Staff knowledge and skill acquisition
- Staff perceptions of resident care and family experience
- Culture change within the collaborative site or facility
- Organizational/system improvements
- Quarterly data submission and review
- Cross-Canada comparative impact analysis – control group using interRAI data
Mississauga long-term care homes eager to reduce use of antipsychotic meds
Yukon receives funding for national project on dementia care
Royal Ottawa part of project to reduce use of antipsychotic drugs by dementia patients
Kitchener nursing home gets grant to reduce use of anti-psychotic drugs in elderly
Leisureworld part of collaborative to reduce antipsychotic medication use
Partnering with Patients and Families for Quality Improvement Collaborative
"...maybe we should ask patients what they think."
Patient, Family and Community Engagement

Patient, family and community engagement is the involvement of these groups in decision-making and active participation in a range of activities (e.g. planning, evaluation, care, research, training, and recruitment).

Starting from the premise of expertise by experience, patient, family and community engagement involves collaboration and partnership with professionals.

Engagement Capable Environments: leadership, staff and patients, families and communities (P,F&C)

Enlisting and Preparing P,F&C

Asserting patient experience and patient-centered care as key values and goals

Communicating patient experiences to staff

Ensuring leadership support and strategic focus

Engaging staff to involve P,F&C

Supporting teams and removing barriers to engaging P,F&C and improving quality
Partnering with Patients and Families for Quality Improvement Collaborative

22 Collaborative Teams

11 Faculty Members

17 Expert Coaches

Alberta
- Glenrose Rehabilitation Hospital
- Stollery Children’s Hospital

British Columbia
- BC Cancer and BC Children’s Hospital
- Island Health
- Vancouver Coastal Health and Fraser Health

Quebec
- Centre hospitalier de l’Université de Montréal
- Centre de santé et de services sociaux de l’Énergie
- Centre de santé et de services sociaux Lévis-Marie Curie
- McGill University Health Centre

Saskatchewan
- Prince Albert Parkland Health Region

Ontario
- Bridgeway Active Healthcare
- Bruyère Continuing Care
- Children’s Hospital of Eastern Ontario
- Grey Bruce Health Services
- Huron Perth Healthcare Alliance
- Niagara Health System
- Ontario Renal Network
- Owen Sound Family Health Team
- St. Joseph’s Healthcare Hamilton
- Sunnybrook Health Sciences Centre

Yukon
- Child Development Centre - Whitehorse

Nova Scotia
- Capital Health

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Collaborative Aim

**Aim:** to build capacity and enhance organizational culture to partner with patients and families in order to improve quality across the healthcare continuum.
Care Environments

- 7 Primary care and community care
- 4 Rehabilitation or continuing care
- 9 Acute care: 7 adult & 2 pediatric
- 2 Mix of acute care and cancer agencies
The Difference Engagement Makes

- Improvements to engagement
- Improvements to quality (patient experience)
- Organizational impacts

<table>
<thead>
<tr>
<th>PFCC</th>
<th>17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency</td>
<td>15</td>
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<tr>
<td>Coordination</td>
<td>6</td>
</tr>
<tr>
<td>Equity</td>
<td>5</td>
</tr>
<tr>
<td>Effective &amp; Appropriate</td>
<td>4</td>
</tr>
<tr>
<td>Safety</td>
<td>2</td>
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<tr>
<td>Access</td>
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</tr>
<tr>
<td>Pop. Health</td>
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</table>
IAP2 Spectrum of Public Participation

**Inform**
To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.

**Consult**
To obtain public feedback on analysis, alternatives and/or decisions.

**Involve**
To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.

**Collaborate**
To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.

**Empower**
To place final decision-making in the hands of the public.

---

**Promise to the public**
- We will keep you informed.
  - We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.

- We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.

- We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.

- We will implement what you decide.

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**Example techniques**
- Fact sheets
- Web sites
- Open houses
- Public comment
- Focus groups
- Surveys
- Public meetings
- Workshops
- Deliberative polling
- Citizen advisory committees
- Consensus-building
- Participatory decision-making
- Citizen juries
- Ballots
- Delegated decision

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Improved health outcomes and changes in service utilization

Patient & organizational improvements e.g. patient experience, safety and effectiveness

Changes in improvement priorities and resources for chronic care

Factors influencing engagement:
- **Patient** (beliefs about patient role, health literacy, education)
- **Organization** (policies and practices, culture)
- **Society** (social norms, regulations, policy)
Methods and measures used by the 22 teams

- Patient experience (satisfaction) of care: surveys, interviews
- Team effectiveness / collaboration surveys
- Readiness to partner with patients,
- Patient involvement in care decisions; Caregiver burden
- Provider capacity to facilitate pt engagement in self-care management
- Emotion mapping, kaizen events, PDSAs
- Participation rates
- Patient outcome clinical measures: HA1c, LDL, BP, wt
- Staff measures: satisfaction, competencies, co-design experience
# Collaborative Assessment Scale

The collaborative average:

- **At time 1**: 1.7 (Between the planning the project and activity, but no change phase)
- **At time 2**: 2.7 (between the changes being tested and some improvement phase).

<table>
<thead>
<tr>
<th>Outstanding Sustainable Results</th>
<th>Highest Score on PRW2</th>
<th>Highest Score on PRW1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BCG</td>
<td>BDF</td>
</tr>
<tr>
<td>Outstanding Sustainable Results</td>
<td>5.0</td>
<td></td>
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<tr>
<td>Sustainable Improvement</td>
<td>4.5</td>
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<td>Significant Improvement</td>
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<td>Improvement</td>
<td>3.5</td>
<td>*</td>
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<tr>
<td>Some Improvement</td>
<td>3.0</td>
<td>*</td>
</tr>
<tr>
<td>Changes Being Tested</td>
<td>2.5</td>
<td>*</td>
</tr>
<tr>
<td>Activity but No Change</td>
<td>2.0</td>
<td>*</td>
</tr>
<tr>
<td>Planning the Project</td>
<td>1.5</td>
<td>^</td>
</tr>
<tr>
<td>Forming</td>
<td>1.0</td>
<td>^</td>
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</tbody>
</table>

* Assessment Scale Adapted from IHI

5highest Score on PRW2

^ Scored on PRW1 (in case of split score, higher number is taken)
Team Data Sources

Team Experience and Effectiveness

Documents:
- Storyboards
- Worksheets
- Reports

Team Experience and Effectiveness Chart

Team Collab Scale
- 5.0
- 4.5
- 4.0
- 3.5
- 3.0
- 2.5
- 2.0
- 1.5
- 1.0
Patient Engagement Resource Hub

Looking for tools and resources to support you on your patient engagement journey?
Start at the Patient Engagement Resource Hub!

Our online resources can help at the stages of assessing, designing, implementing or evaluating your initiative.
For more information:
www.cfhi-fcass/PatientEngagementResourceHub
Quality Improvement Collaboratives (QICs): What Works

Focus on improving provider practices or patient outcomes

Structure activities for individual and also cross-team learning

Combine expert evidence in EBM and QI within an improvement model that prioritizes measurement and feedback

Rely on multidisciplinary teams (including patients and families) executing small tests of change

Nadeem E. et al. (2013). Understanding the components of quality improvement collaboratives: A systematic literature review. Milbank Quarterly.
QICs: CAUTIONARY ADVICE

Don’t assume people know the basic QI methods needed to measure, test and study changes

Don’t be overly ambitious

Don’t expect collaboratives to address systemic problems

Don’t expect it to work everywhere, every time

4 Collaboratives: Lessons Learned to date...

Successes...
- Adoption, adaptation, spread
- Collaborations, networks, results
- Better care, better health, better value

Challenges...
- Collaborative time horizon
- Sustainability
- Spread to scale
Key Challenges going forward

Sustainability – providing support once Collaborative ends

Spread - continue spread within organizations/regions and across the Collaborative

Scale – getting to scale after the Collaborative

Criteria for selection – what to work on next?
Thank you!

Questions?

Discussion...

Stephen.Samis@cfhi-fcass.ca

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