afhto association of family health teams of ontario

# CASE STUDIES

## BUILDING COLLABORATION AND INCREASED CAPACITY THROUGH QUALITY IMPROVEMENT DECISION SUPPORT PARTNERSHIPS


## Summary

In 2013, the Ministry of Health and Long-Term Care approved funding for the Quality Improvement Decision Support (QIDS) program for Family Health Teams. The following case studies document the experience of five Family Health Team partnerships that employ Quality Improvement Decision Support Specialists (QIDSS).

The manner in which the partnerships are organized, falls into three models:

- Model 1 – QIDSS' time is shared equally among the partners; focus of work is to ensure provision of data for the Ministry, QIPs, D2D and data analysis.
- Model 2 – the allocation of QIDSS time is project based; primary focus of work is to ensure provision of data for the Ministry, QIPs, D2D and data analysis.
- Model 3 – a LHIN-wide model, three QIDS specialists focus on specific elements of Quality Improvement (strategy, data, programs and evaluation). QIDSS' time is allocated according to the projects s/he is working on; focus of work includes provision of data for Ministry, QIPs, and D2D, data analysis, strategy and evaluation.

The partners in all models identified QIDS successes in their collaboration. The following achievements stand out:

- Quality Improvement is now top of mind. Before embarking on new initiatives, FHTs now consider whether they have access to the necessary data sources.
- The QIDS program is stimulating the development of a culture of QI, helping to ensure the alignment of all of the important elements of quality, from data through to governance, strategic planning and risk management.
- QIDS partnerships have in many cases improved overall collaboration and trust among FHTs.

Partners identified challenges in rolling out the QIDS program that fall into four broad categories:

- Resources
- Diversity of FHTs
- Reaching agreement among partners
- Leadership

Partners also identified the following enablers that were instrumental in ensuring the success of the QIDS initiative:

- Pre-existing collaborative working relationship among partners
- QIDSS work plan
- Leadership including clinical champions
- AFHTO support, coordination and advocacy
- QIDSS expertise
- Regular meetings and check-ins
- Remote access to EMRs
- Data sharing agreements

The experience FHTs gain in collaborating to provide higher quality care will be particularly beneficial as Ontario moves forward to provide and improve integrated, patient-centred care within subLHIN regions.


## Introduction

In 2013, the Ministry of Health and Long-Term Care approved funding for the Quality Improvement Decision Support program (QIDS) for Family Health Teams. There are currently about 34 Quality Improvement Decision Support Specialists (QIDSS) supporting Family Health Team partnerships across the province to "… access and use data better to improve care." (AFHTO, June 1 2015). More specifically, they "… assist FHTs in meeting their quality improvement objectives through data standardization and extraction, information production and on-going analysis." (AFHTO, June 1, 2015).

Under the Patients First[1] agenda, the Ministry of Health and Long-Term care is moving toward a patient-centred system of geographic-based, risk-adjusted, population-based primary care. The Ministry is also exploring how to connect services – delivering better coordinated and integrated care in the community. At this time, subLHIN regions are being used as the geographic basis for planning and evaluation. The relatively small size of subLHIN regions presents an opportunity for organizations to collaborate in the identification of data-driven areas of focus for quality improvement across health care providers.

[1] Ministry of Health and Long-Term Care, Patients First: Action Plan For Health Care. Queens Printer for Ontario, 2015. Web. 19 Apr. 2016.

# BUILDING COLLABORATION AND INCREASED CAPACITY THROUGH QUALITY IMPROVEMENT DECISION SUPPORT PARTNERSHIPS

The following documents the experience of five Family Health Team partnerships that employ Quality Improvement Decision Support Specialists (QIDSS). Their experience is compiled from 17 interviews we conducted with QIDS hosts, partners and staff and presented within three broad models of QIDS partnerships. The experience that partners have gained in collaborating to provide higher quality care will be particularly beneficial as Ontario moves forward to improve and provide integrated, patient-centred care within subLHIN regions. The manner in which the partnerships are organized, fall into three models:

- Model 1 – QIDSS' time is shared equally among the partners; focus of work is to ensure provision of data for the Ministry, QIPs, D2D and data analysis.
- Model 2 – the allocation of QIDSS time is project based; primary focus of work is to ensure provision of data for the Ministry, QIPs, D2D and data analysis.
- Model 3 – a LHIN-wide model, three QIDS specialists focus on specific elements of Quality Improvement (strategy, data, programs and evaluation). QIDSS' time is allocated according to the projects she is working on; focus of work includes provision of data for Ministry, QIPs, and D2D, data analysis, strategy and evaluation.

Following the description of the three models, the discussion will focus on the challenges, enablers, advice and lessons learned.

## Model #1

### Description

In this model, the QIDSS' time is shared equally among the partners with the focus of work to ensure provision of data for the Ministry, QIPs, D2D and to conduct basic data analysis. Several of the QIDS partnerships we surveyed have established a fixed, rotating schedule for QIDS staff. Partner FHTs receive equal time and attention from QIDSS who typically travel to each FHT on a regular rotation.

Within this model are two variations in setting QIDSS' priorities:

- Each FHT establishes its own priorities for the QIDSS who tailors his/her support accordingly;
- The partner FHTs establish a joint annual work plan with identified priorities that becomes the QIDSS' work plan.

Model #1 allows QIDSS time to be targeted where individual FHTs require the most support. It also takes into consideration each FHT's capacity around data management and quality improvement. Some FHTs have dedicated resources in the areas of IT, program planning and evaluation, while others need to rely more heavily on the QIDSS.

### QIDSS Role

The role of the QIDSS in this model depends on where the individual FHT lies on the quality improvement continuum and on what capacity the FHT has in IT and quality improvement.

Teams that do not have dedicated resources (mostly smaller and/or newer teams), rely on the QIDSS for data extraction and analysis, and for the completion of required reports (Schedule A, QIP, D2D).

At other FHTs, the QIDSS are providing education on quality approaches, establishing quality frameworks and the QIPs, and analyzing data produced by the FHTs.

Some of the specific responsibilities of the QIDSS include:

- Converting patient experience surveys from paper to electronic platform; developing the questions, preparing one common survey tool for all partners.
- Conducting surveys on population health indicators.
- Completing the QIP and monitoring progress.
- Attending internal QIP meetings to review the plan and work on change management.
- Presenting data to the Boards and teams.

### Successes

> *She is the glue for all six FHTs and the conversation has changed from 'I need her most' to real mutual respect for others' needs.*

The FHTs we interviewed were enthusiastic about the role of the QIDSS. One partnership has been struggling with the issue of how to focus attention on common, shared goals (see Challenges), but in general the partnerships point to the following successes of the QIDS initiative:

- Increased collaboration across the partner FHTs
- The consolidation of data across partner FHTs
- Development of a common D2D dashboard that demonstrates how individual FHTs are doing amongst one another and against the province

- Development of a real sense of trust and transparency across the partner FHTs
- Development of standardized data sets, and an increased assurance that data is being entered into the EMR in a consistent way.

> *This allows us to be more strategic; we see trends and themes, we can relate our experience to what HQO is doing, information can be useful to AFHTO advocacy work and for D2D.*

## Model #2

**Description**

The approach some partnerships have taken to allocating QIDSS time is project-based. Most QIDS projects are those that have been determined to benefit the entire group, though in some instances individual FHTs have additional project needs that are specific to them.

The approach generally begins with a compilation of all needs from partner FHTs relating to data (e.g. standardization, analysis, reporting) and quality (QIP preparation, analysis, reporting, etc.). The partnership then commits to an annual work plan for the upcoming year that guides the QIDSS. In one partnership, the QIDSS' time is allocated relatively equally among the FHTs; in another, the projects themselves, together with the FHTs' capacity, determine how the staff time will be allocated. As much as possible, the common projects are given highest priority, as they tend to produce the greatest benefit for all partners.

> *Our FHTs wanted to know the % of patients being seen at the FHT within seven days of hospital discharge. Our QIDSS developed a process to find reports from the hospitals, and send messages to the physicians and clerical staff reminding them to arrange to see patients. She developed a process map for us and worked with the team to make it happen.*

**QIDSS Role**

In the FHTs that use a project-based approach, the role of the QIDS staff is similar to the above model: they work broadly across the FHTs to support the work on shared project priorities, and they work with individual FHTs to enhance the team's capacity in such areas as data integrity, metrics and reporting.

In general, the QIDSS:

- Supports the QI initiatives by participating on QIP committees and assisting with framing of objectives and indicators to align with Health Quality Ontario requirements.
- Develops tools and applications for the FHTs to use to collect and extract data (both inside and outside the EMR).
- Establishes data standards and helps FHTs to cleanse their data and improve data integrity.
- Helps FHTs to collect and analyze data for various reports and submissions (Schedule A, QIP, D2D, internal).
- Establishes key metrics for all of the FHTs – D2D, QIP metrics, and then specific metrics that each team might want.
- Collects and analyzes the patient satisfaction survey data (bi-annually). Some partnerships developed a common set of questions and then added questions for individual FHTs, as required. Results are reviewed bi-annually (for each team) and on a consolidated basis.
- Gets Ministry and ICES data for the FHTs and pulls it together.

Specifically, for each team, the QIDSS:

- Develops and/or supports the development of QI plans
- Supports the collection and analysis of specific Schedule A metrics
- Develops other metrics that each team wants/needs for its own use

> *At the first meeting we created an annual work plan. This worked really well. Before this meeting happened the EDs all compiled a list of their top 10 needs with respect to data and QI. We discussed all of these as a group and identified a number of common projects that became priority. In the process of doing this, all of the EDs realized what the others were doing, and this was great information sharing.*

**Successes**

One of the most notable achievements reported by the partnership has been the ability of the partner FHTs to identify common priorities for quality improvement and to allocate resources to achieve shared goals. This may mean that the QIDSS' time is not divided equally across the FHTs, but

the priorities of a shared work plan drive the allocation of resources. Other successes identified by the partners are similar to Model #1:

- Increased transparency, leading to better ability to analyze, compare and learn from the data
- Increased trust amongst the partners
- Much improved standardization of data (within and across FHTs)

## Model #3

**Description**

This cross-LHIN model was developed by the FHT Executive Directors at the outset of the QIDS initiative. There are 21 FHTs supported by three QIDSS. Each QIDSS has a distinct role:

- Strategy and Reporting – One QIDSS provides direction in strategic planning including SWOT analysis, goals, objectives and strategies; Board development; and provides support for Ministry reporting.
- Data – The second QIDSS is responsible for overseeing data collection, planning and EMR optimization; assists teams with building capacity for data extraction and quality reporting; performing quality/efficiency assessments, EMR training; development of data collection tools; data interpretation. S/he works with EMR providers and is the liaison with other EMR users in other parts of the province.
- Programs and Surveys – The third QIDSS supports the development of programs, including performance measures; develops, analyzes and reports on yearly standardized patient experience survey; leads QI initiatives resulting from survey results; supports the francophone teams.

> *"Our model stems from a desire for innovation and systemic change.*

Each QIDSS broadly supports seven teams, and specializes in one of the above areas. The protocol is that the FHTs call their assigned QIDSS first with any requests for support and depending on the specific need, the call is referred to the QIDSS with specific expertise.  This is a single point of contact approach.

Partner Executive Directors are consulted about priorities. The host Executive Directors then set the work plans for the QIDSS in a way that accommodates the needs of the majority of FHTs.

**QIDSS Role**

The most notable distinction in this model is in the role of the QIDSS. QIDSS are not typically hands-on mining data, correcting data, doing queries and reports from the EMR. It is expected that the FHTs will do this work. QIDSS develop the process for ensuring quality data and the framework for queries and reporting.

> *"The small FHTs benefit most from process optimization; the larger FHTs benefit most from system optimization*

Partners are discouraged from monopolizing one QIDSS and rather, are encouraged to use them as a team. The work that the QIDSS do must meet a greater good – i.e. be a reproducible concept across the partnership or improve group efficiency. Together, the 21 FHTs have taken the position that QIDSS are here for the collective good of the partnership, not for individual FHT benefit.

The QIDSS filter requests for support using the above lens. Communication is key. When QIDSS are unable to meet the needs of a FHT or group of FHTs, they provide a thorough explanation so that everyone understands the issues and feels heard.

**Successes**

The partners feel that this model has been very successful. The three QIDSS work closely together, and the partner FHTs have achieved a level of consistency over a fairly short period of time. For example, all FHTs now use the same patient experience survey, which is getting close to 100% compliance.

The QIDSS speak regularly to ensure that the work they each do is aligned with one another and with organizational priorities and programs. They created a Sharepoint site for Executive Directors. Information that is shared includes:

- Best practices
- QIDSS work in progress
- Survey results
- Training documents

# BUILDING COLLABORATION AND INCREASED CAPACITY THROUGH QUALITY IMPROVEMENT DECISION SUPPORT PARTNERSHIPS

There is a common QIDSS e-mail account for all three QIDSS. This makes it easy for Executive Directors to reach the QIDSS, even if they don't know which QIDSS is the "right" one to contact for a particular issue.

The QIDSS also developed and share a FHT database. This database contains relevant information about all of the FHTs (size, physicians, governance model, EMR, etc.). It also contains all of the QIPs and a program inventory for all FHTs.

The model has demonstrated the ability to take the learning from one FHT, build on it, and disseminate it to others – ultimately to all 21 FHTs. It is a continual building and quality improvement process.

The QIDSS have also developed a focus on improving the "business" side of primary care, on the part of both physicians and staff – significantly, the effective alignment of all organizational activities (e.g. strategic plan, operational plan, quality improvement plan, patient experience). For example:

- With improved data and business processes, one FHT achieved a clean audit for the first time in three years
- With the availability of standardized and relevant data, all partners have developed operational plans
- Training on data gathering has meant that all FHTs are now entering consistent data (some for the first time)
- A common diabetes indicator is being developed across all 21 FHTs

## Discussion

All of the FHTs we interviewed indicated great support for the QIDS resources. Clearly there have been notable successes in improving the integrity of data, standardizing data input, and in data collection and analysis. There are many examples of such improvements including the development of shared indicators, the creation of dashboards and scorecards, and the analysis of performance results. There are also challenges to be overcome when introducing a new role, collaborating with partners, developing an emphasis on data collection and integrity, and in using data to inform decision-making, strategy development and clinical practice.

**Challenges**

The challenges in rolling out the QIDS program fall into four broad categories: resources, diversity of FHTs, reaching agreement among partners, and leadership.

1. **Resources**

   All of the FHTs interviewed were grateful for the QIDSS support, but acknowledged that allocating one staff person across multiple FHTs is challenging (one partnership includes 9 FHTs with one QIDSS). This is particularly true if the partnership covers a very large geography; travel is expensive and time consuming, and resources are scarce.

   The QIDS staff we interviewed felt that more resources were needed for professional development. This is a field that is exploding with knowledge and is advancing rapidly. Many of the QIDSS could benefit from Lean training (Six Sigma or something similar), but it is simply unaffordable.

   > *"We have been so busy working on the 'data' part of D2D that we haven't had time to get to the 'decision' stage*

   While acknowledging the work that AFHTO has undertaken to support the QIDs program, a number of FHTs identified a challenge in balancing the focus on AFHTO's D2D work with local priorities.

2. **Diversity of FHTs**

   The partnerships include FHTs with very different profiles; they may use multiple EMRs across the partnership and have differing capacities and priorities (e.g. academic FHTs, those that serve targeted populations). The needs of the FHTs may be very different based on size and type of team, maturity and resources (a number of the FHTs commented on the disparity in resources based on whether they were an early or late wave FHT). These differences make it very difficult for a QIDSS to develop common frameworks for data extraction and to become a subject expert on multiple EMRs. As well, when the partners have varying needs, their requirement for QIDSS support will also vary. Creating a sense of fairness in allocation of QIDSS time can be an ongoing effort and negotiation.

QIDSS also work within a variety of governance models, and must adapt their approach based on the culture and leadership of the partner FHTs. Some physician-led FHTs are more protective of their EMR data and more cautious about data access and sharing.

3. **Reaching Agreement Among Partners**
   One partnership was struggling to reach agreement on the QIDSS' role and method of time allocation among the partners. There were also diverse perspectives about the necessity of Ministry reporting and the types of projects that the QIDSS should be working on. In these circumstances, a host FHT has no authority or leverage to require cooperation and accountability. These differences make it difficult for the partnership to maximize the potential of the QIDS program. Working as a collective on common projects is a new way of working for many and it requires negotiation and compromise. Partnerships have applied several different strategies to address this challenge, including use of a Steering Committee, development of a shared work plan, and development of a set of shared principles to guide the QIDS work.

   A more basic issue for some QIDSS has been gaining access to EMRs. To optimize the chances of success, partners must be prepared to allow access to data.

4. **Leadership**
   All of the FHTs we interviewed agreed that the role of the Executive Director is essential to the success of the QIDS program; s/he provides leadership and demonstrates to staff and physicians that this is important work. Strong leadership is required to overcome the challenges that inevitably emerge.

   In one of the partnerships we spoke to, the QIDSS felt that their role was marginalized by the Executive Director's lack of commitment.

   Some teams using the project-based approach also indicated that change management can be a significant challenge. Moving teams from ideas to implementation takes time and can be difficult.

   In some instances it has been a challenge to get the physicians to appreciate the value of new data tools and agree to incorporate the tools in the EMR.

   QI culture is new to primary care; it has been a challenge in many FHTs to engage physicians and to incorporate this new culture as a way of doing business.

> *Many FHTs have no experience in strategic planning, risk management or quality improvement. They have been focused on clinical issues, and lack business process experience. There is no standardization (e.g. in EMR coding).*

**Enablers**

The following enablers were instrumental in ensuring the success of the QIDS initiative in the FHT partnerships we interviewed:

1. **Pre-existing collaborative working relationship**
   The QIDS partnerships that had a collaborative working relationship and experience working together on a number of projects prior to QIDS, were one step ahead of those partnerships lacking that experience. Processes for working together were already established. This also made it easier to manage on a project basis as opposed to a strict allocation of hours per FHT; the partners trust one another, they know what the QIDSS is doing at each FHT, and they trust that their needs will be met.

2. **Work Plan**
   A good work plan that is agreed upon by all partners prevents conflict, provides goals, and helps to ensure that the QIDSS' time is allocated appropriately to complete the identified priorities.

3. **Leadership**
   All of the FHTs we interviewed agreed that leadership from the Executive Director is an important enabler for ensuring success. A QI champion among the clinicians is also a huge support (and a necessity when dealing with patient data from physician hosted EMRs).

4. **AFHTO**
   AFHTO played a key role in helping the QIDSS rollout to be successful. The partnerships recognized the value of centralized, coordinated thinking about the QIDSS role. They also felt that AFHTO has kept the program on track. Given AFHTO's advocacy role and involvement in provincial level discussions, AFHTO leadership has helped determine what data analysis will be needed to support ongoing primary care reform.

5. **QIDSS expertise**
   Skilled QIDS specialists with the right expertise and experience are able to contribute greatly to the QI work of the partnership. All Executive Directors agreed that having the right QIDSS with the right skills was key to a successful partnership.
6. **Regular meetings**
   Partners indicated the importance of regular meetings of the Executive Directors to share information, to review progress and to make decisions. They also recommended QIDSS attendance at regular EMR, IT, and QI Committee meetings to ensure that QIDSS work is embedded in the work of the organization.
7. **Remote access to all EMRs**
   Having remote access to EMRs overcomes the need for excessive travel. Travel time is expensive and the geography is often large; there is no reason to be on-site for straightforward data extraction or analysis.
8. **Data Sharing Agreements**
   Agreements between the host FHT and partners can facilitate the work of the QIDSS. Data can be accessed easily, and analysis can be shared across the partnership.

**Advice and Lessons Learned**

Quality improvement is a rapidly growing priority in primary care. The QIDS initiative has helped to focus the attention of Family Health Teams on a number of practice elements that contribute to quality care.

The following achievements stand out as QIDS successes:

- The establishment of a culture of Quality Improvement; it is now top of mind. Questions around data sources and data collection now accompany the development of new programs and projects. Before embarking on new initiatives, FHTs now ask the questions "do we have this data?" or "can we get this data'"?
- Related to developing a culture of QI, the QIDS program is encouraging the alignment of all of the important elements of quality, from data through to governance, strategic planning and risk management.
- Improved collaboration among FHTs. In several of the partnerships we interviewed, reports were all anonymous at the outset. Now data and reports are shared openly between the partners, which has been very helpful. Partners were all curious to know who was doing better – not for competitive reasons but to be able to understand 'why' and then to disseminate the learnings across the partnership.

The partnerships we interviewed offered the following advice and lessons learned to optimize the QIDS experience:

1. **The Model**
   It is important to establish the foundation and the terms of the partnership. On what basis are decisions made? How will QIDSS' time be allocated (e.g. pro-rated based on the size of the team? Rostered patients? An annual work plan? Shared priorities? Equal time per team?). Where teams are not experienced working together, a Memorandum of Understanding can be helpful.

   At the outset an equal allocation of QIDSS time may be a good place to begin, as it establishes trust among the partners. However, not all FHTs require the same level of support as they may have their own internal resources; over time a more flexible schedule can produce improved results overall as support is targeted to specific areas where it can produce the best results for the whole partnership. Interestingly, one of the partnerships noted that focusing on bringing all FHTs to a similar level of capability in data collection as a first step, (i.e. dedicating QIDSS time where it is needed most) can then lead to more equitable allocation of QIDSS time at the next stage which generally involves a higher level, more sophisticated approach to quality improvement.
2. **Start small and build in time for learning**
   It is important early on to set reasonable expectations and remember that the QIDSS may be learning a number of EMRs and working with several different teams.

   Start with a small, common project that will benefit all of the partners to build trust and collaboration and help FHTs understand the value of the role. Look for things that the partners have in common and start with those (e.g. a patient experience survey or preparation for meeting the standards for ARI). This gives everyone an appreciation of the work of the QIDSS.

3. **The Annual Work Plan**
   A shared work plan can guide the work of the QIDSS. Additionally, this can become the basis for an annual performance evaluation.

4. **Recognize the diversity within your partnership**
   The partner FHTs are often very different from one another – in size, in culture, in resources, and in approach. One of the urban FHTs we interviewed noted that they have more in common with FHTs outside their geography than with their neighbours. Not all FHTs require the same level of support. It is important to acknowledge the differences between FHTs, and to agree as a group on how best to use QIDS resources to move toward common goals. For some FHTs, data standardization might be the most pressing challenge, while for other FHTs, using the data to inform program planning might be a priority.

5. **The QIDS Staff & Role**
   It is important for all FHTs in the partnership to understand and agree upon the role of the QIDSS. There can be tension in partnerships where some partners have given the QIDSS a predominantly clerical/administrative role like data cleaning instead of maximizing the staff's expertise; or where some partners have used the QIDSS to support their priority projects, which may not be of benefit to other partners. Shared agreement on the goals and expected outcomes of the QIDS program can help to ensure that QIDS work can be tailored to individual FHT needs while also contributing to collective progress. Some partners felt that, in circumstances where partnerships cannot reach agreement on role and function, it would be helpful if the Ministry would be more prescriptive. However other partners indicated that the flexibility provided by the Ministry supports the development of solutions that are responsive to the unique needs of the partners.

   The Executive Directors we interviewed talked about the importance of recruiting the right person for the role. QIDSS must be very skilled, good communicators, flexible staff who are able to work with the different needs of many teams, and the variety of demands from Executive Directors, staff, Boards and physician groups. The recruitment process is very important, starting with a shared understanding of the role, and the skill set that will be required. It is also important that all partner FHTs participate in the performance review of the QIDSS, not just the host FHT. Understanding the perspective of all of the partners is important to ensuring the success of both the QIDSS and the partnership itself.

   It is important for QIDSS to be involved in program planning. Indicators and data measures need to be developed in concert with the programs themselves. These pieces must be linked.

   All interviewees said that the QIDSS' role is evolving as the FHTs learn more about how they can use QIDSS and as the QIDS specialists become more familiar with the EMRs and more knowledgeable about the needs of the partnerships.

6. **Leadership**
   The host ED role is very important to establishing the tone of the partnership, ensuring good collaboration, mediating any disputes, etc. In some instances, there has been tension between FHTs based on the sense that the host FHT has become a "favoured FHT", receiving more funding, and more profile. FHT leadership must be sensitive to and must navigate these political realities to produce a productive working relationship and partnership.

7. **Evaluation**
   There is strong support for the QIDSS role, and much anecdotal evidence of the success of the QIDS initiative. The anecdotal evidence includes such things as improved collaboration, improved integrity of data, more consistent reporting, etc.

   Now that the partnerships have been established and are well underway, it may be helpful to consider some specific evaluative criteria that will a) continue to shape expectations provincially and within the partnerships and b) ensure that all FHTs have reasonable and measureable targets for quality improvement.

8. **QIDS Evolution**
   There is a logical evolution in the development of an effective QIDS partnership. In the early days, focus is on developing tools and improving the integrity of the

BUILDING COLLABORATION AND INCREASED CAPACITY THROUGH QUALITY IMPROVEMENT DECISION SUPPORT PARTNERSHIPS

*"This role is bigger than data. QI is about understanding how everything fits together. Right now the biggest challenge is in moving our thinking from 1:1 patient care to a population-based data framework.*

data. As the FHT partners reach a level playing field, the role of the QIDSS can be enhanced and expanded. The focus can move from data input and collection to making good use of the information to improve patient care.

9. **Build Trust**
   Building trust takes time and effort. Participants found that beginning with small, mutually beneficial projects, where goals can be shared and success can be achieved relatively quickly and can be measured (e.g. a shared patient experience survey, development of standardized data sets, etc.) assisted in building trust and understanding among partners. Written agreements help ensure that goals, expectations, processes, and behaviour are understood and shared. Having open and honest conversations to resolve tension or conflict helps to build a foundation for a productive working relationship.

10. **Foster Communication and Transparency**
    Executive Directors and QIDS specialists need to communicate often, and need to meet frequently (not necessarily always face-to-face) to review progress, establish priorities and resolve conflict. Skilled leadership is required to foster open communication. EDs and QIDSS that shared information and were transparent without being judgmental (for example, begin by sharing information anonymously, and when trust grows, decision can be made about when and how to remove anonymity) found most success.

11. **Focus on Quality**
    Robust data is an essential input to improving the quality of care; however, a culture of quality improvement extends beyond data to every aspect of FHT operations. Achieving this culture requires FHTs to continually look for ways to improve performance, to measure that improvement, and implement change. For many QIDS partnerships, this approach has become second nature such that all elements of FHT operation are linked to one another and to the principle of quality (e.g. strategic planning, data, governance, QIPs, risk management).