

# Partnerships for Health

A Chronic Disease Prevention and Management Demonstration Initiative

**W**ELCOME to the Partnerships for Health Bulletin, designed to keep you in the know about our exciting initiative. In the third edition we explore how the outcomes of this important initiative will be evaluated, and learn about the business process mapping activities.



## Measuring Success

The Thames Valley Family Practice Research Unit is responsible for evaluating Partnerships for Health

Partnerships for Health (PFH) is an initiative that puts the principles of Ontario's Chronic Disease Prevention and Management model into practice. Evaluation is a critical component of the work and thanks to the help of the Thames Valley Family Practice Research Unit (TVFPRU), the outcomes will be captured and quantified in order to provide information that will drive system improvements across Ontario.

Jann Paquette-Warren, Qualitative Project Coordinator with TVFPRU, says evaluation can take a number of different forms, both quantitative and qualitative. "It's not just about clinical outcomes," she says. "It's also about how the initiative was implemented, what was learned, and how we can improve next time. Evaluation has to be comprehensive in terms of what was delivered and how it was applied."

Paquette-Warren says PFH is especially challenging to evaluate, given its complexity and tight timelines. The evaluation will be divided into two parts – one focusing on delivery of activities and processes, and the other focusing on outcomes. "Because the timeline is so tight, we may not see dramatic changes in the quantitative clinical measures," she says. "By looking at process, we can capture things like patients feeling more empowered or teams working better together." There will be four levels of evaluation: the project management team, providers who are participating in the learning collaborative, other providers in the group practices, and patients.

Evaluation tools will include surveys, qualitative interviews, focus groups and chart reviews. "The surveys are great at capturing a lot of information in one shot," says Paquette-Warren. "The interviews and focus groups allow us to dive into people's experiences and give them a chance to say what they want to say." Each tool will be implemented at two different times – at the outset and about six months after the Learning Collaborative sessions have been completed – to demonstrate change. Patient data will be obtained through chart reviews and will be collected in the aggregate, to protect patient privacy and confidentiality.

*"This has the potential to be very important information for the health system as a whole."*

Once all the data is collected and analyzed, it will be pulled together into a report and shared with the participants and health system partners. The lessons learned will help inform policy at the Ministry of Health and Long-Term Care, improve the collaboration amongst health professionals, and, most importantly, the quality of care for patients.

"With an initiative like this, evaluation is critical," says Paquette-Warren. "We need to be able to demonstrate success and to show that the intervention was the reason for obtaining the outcome; or to pinpoint why the outcome wasn't achieved. This has the potential to be very important information for the health system as a whole."

## Roadmap to better care

Business process mapping helps identify opportunities for improvement



**In September the three Partnerships for Health (PFH) teams will be involved in an exciting new approach to understanding one another and improving care for adults with diabetes.**

Business process mapping is an activity designed to define, document and improve a process. In this case, the PFH teams will be mapping the process that a patient undergoes from the point of diagnosis through ongoing primary and community care to avoid complications and emergencies.

Gavin Giles, e-Health lead, says the mapping approach will help all team participants understand how each member contributes to the continuum of care. “Now that we’re working together, the team members are interested in knowing more about how each other provides care,” he says. “The really exciting thing is that this is not only an opportunity to describe what happens currently, but also to think about what could happen in the future.”

The business process mapping is happening by bringing representatives from the Family Health Teams (FHTs), the South West Community Care Access Centre (CCAC) and local Diabetes Education Centres (DECs) together for two to three days to develop their map. They will be supported by Giles and Pamela McLaughlin-Skinner. McLaughlin-Skinner is Dean of Health Sciences and Human Services at Fanshawe College, and an experienced facilitator and researcher.

The result will be a visual representation of the care process, and a greater understanding by team members of how their work currently flows and how processes could be improved. “This is an opportunity for these teams to demonstrate leadership and influence chronic care delivery in Ontario based

on what they’ve found to be valuable to patients,” says McLaughlin-Skinner.

Giles hopes that by going through the mapping process now, the teams will be better equipped to integrate other providers as implementation of chronic disease prevention and management programs expand across the system. “We think this will meet the immediate needs of the PFH participants,” he says, “and then provide a solid foundation for future work, including adoption of integrated electronic health systems.”

For team members, the biggest benefit is educational, Giles says. “Providers will better understand the work of their colleagues and how they can best work with them. Right now the FHTs, South West CCAC and DECs operate on separate sites, often duplicating work efforts. This is an opportunity for all members of the team to understand what’s happening at each site and plan the most efficient pathways for the patient to move through the system.”

### COMING NEXT ISSUE:

The South West has been identified as an early adopter for Ontario’s e-Health and diabetes strategies. This great news means that more primary care professionals can participate in the Partnerships for Health initiative. Look for information on how to get involved in the next PFH bulletin.

For more information about Partnerships for Health:

**519-640-2594 • 1-866-294-5446**  
[www.partnershipsforhealth.ca](http://www.partnershipsforhealth.ca)

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