Improving care

for people with Diabetes

Orientation Meeting Proceedings Report

Quality Collaborative
Diabetes

Capital Health | Primary Health Care & District Department of Family Practice

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Quality Collaborative: Diabetes Orientation Meeting Proceedings Report
Prepared by Primary Health Care, Capital Health and Pyra Management Consulting Services Inc. April 2011.

Introduction

One of the ways Capital Health is supporting quality improvement in Primary Health Care is through the Quality Collaborative: Diabetes initiative. The purpose of this new and exciting learn by doing "Collaborative" is to improve care and outcomes for patients living with diabetes in participating practices. The initiative is open to a number of family physician practices within Capital Health.

Improvements occur by finding practical ways to incorporate evidence into practice. Participating leading-edge family practices will take part in four one-day Learning Workshops over a year where they share exchange ideas, develop improvement change strategies, and share results. Participants test and implement changes, collect data, and track improvements in the Action Periods between workshops. Monthly data collection of key improvement measures will take place for a total of 18 months in all participating practices with findings and learnings to be shared with others once all the data is analyzed.

On March 3, 2011, the Quality Collaborative: Diabetes coordinated by Capital Health hosted an Orientation session for family physicians interested in learning more about the "Collaborative". The purpose of the meeting was to:

- Provide an opportunity for potential participants to become acquainted with each other and the Improvement Team;
- Provide an overview of the intent and process of the Quality Collaborative: Diabetes;
- Provide participants with a clear understanding about expectations of those who choose to participate;
- Inspire participants to participate in the Quality Collaborative: Diabetes; and
- Provide an overview of next steps.

This report provides an overview of proceedings from the meeting. Slides from the presentations given at the meeting are available by contacting qualitycollaborative@cdha.nshealth.ca.

Quality Collaborative: Diabetes - Overview

Dr. Rick. Gibson, Chief of District Department of Family Practice and Lynn Lowe, Project Manager, Primary Health Care, Capital Health presented an overview of Quality Collaboratives. Highlights from the presentation included:

- Quality Collaboratives in PHC are widespread and proven to work in Europe, US, Australia, and Canada;
- "Collaboratives" offer many benefits including supporting optimal chronic disease management in clinical practice;
- Based on several models including the Institute of Healthcare Improvement's Model for Improvement;
- This " Collaborative" is smaller scale than other jurisdictions and will be a learning process for Capital Health and participants;
- Will be looking to participants to help us test and improve the Collaborative process;
- Diabetes was selected as the first topic due to increasing numbers of people with diabetes in Nova Scotia and evidence that those diagnosed do not receive recommended care;
- Specific measures will be captured as part of the Quality Collaborative: Diabetes that are based on current guidelines, leading practice in delivering care, and input from an Expert Panel;
- "Collaborative" participants will take part in four one-day Learning Workshops over a year period and trial practical, small scale improvements in Action Periods in between using the Model for Improvement;

- The initiative will be evaluated through collection of data on Measures, patient and physician surveys and a participant focus group.

Practice Facilitation to Support the Collaborative

Graeme Kohler, Project Manager, Primary Health Care presented an overview of the practice facilitation support available for the Collaborative. Highlights of the presentation include:

- Practice Facilitators are health professionals who assist primary care clinicians with research and or quality improvement activities and are found in England, Australia, Netherlands, New Zealand, USA and Canada.
- There are several effective models in use to provide guidance for Capital Health's introduction of practice facilitation.
- Some of the key roles of the practice facilitator will be in facilitating data collection, assisting to spread learning across practices, and providing feedback to the improvement practices/ teams.
- Encourage participating practices to meet with the practice facilitator at least once before Workshop 1.

Quality Collaborative: Diabetes – Data Collection

Lynn Edwards, Director of Primary Health Care, Capital Health presented a brief overview of the importance of measurement and the data collection and reporting expectations of Quality Collaborative: Diabetes participants. Highlights from the presentation include:

- Routine tracking of results and PDSA's are for monitoring & improving purposes.
- There will be multiple options to track Measures including encounter sheet, excel sheet and EMR print out. Capital Health will work with practices to support their choices.
- Developing a practice registry is the first step. This registry can be simple or sophisticated.
- A Privacy Impact Assessment has taken place and implied consent of patients is sufficient to share data. Practice posters, patient hand-outs and opt-out forms are available.

Collaborative Logistics

CME credits: Capital Health will seek accreditation through the College of Family Physicians and Surgeons for the Quality Collaborative: Diabetes workshops. Details of how to receive these credits can be found in participants binders.

Practice Agreement: Participating practices will be required to sign an agreement with Capital Health which outlines practice expectations and Capital Health supports for the Quality Collaborative: Diabetes.

Practice Remuneration: Practices will be remunerated for their participation in the Quality Collaborative: Diabetes as detailed in the participant binder and practice agreements.

Next Meeting: East Dartmouth Community Centre: Meeting Rooms A, B and C, 50 Caledonia Road, Dartmouth,

NS, free parking.

Next Steps: For those participants who commit to participating in the Collaborative, Margie will connect with each practice to set up appointments to provide support as necessary.

Key Messages Communicated to Participants

- The Diabetes Collaborative is being coordinated by Capital Health as part of the ongoing efforts to improve primary health care and specifically, chronic disease management.
- This is the first time Capital Health has implemented a Collaborative, so the process will be a learning process for everyone. Lessons learned from this experience will inform the roll out of future Collaboratives.
- The Collaborative provides an opportunity for participants to think and learn with their colleagues, and to explore changes in practice that can result in better outcomes for patients.
- The Collaborative will use the IHI Learning Model: Plan, Do, Study, Act.
- Participants get to identify changes that they believe will work in their practice, and then test the changes to see what impact they have.
- Capital Health will provide supports and tools to assist participants in making the changes they wish to try and implement in their practice.
- Capital Health is providing a practice facilitator who will meet with each participating practice to support their change efforts.
- There is an evaluation process for the Collaborative that all participants will be a part of; this will be discussed further at the next meeting.
- CME credit is available for physicians participating in the Collaborative.

Thoughts and Ideas Expressed By Participants

- There needs to be an effort to support a cultural shift so that the public understands the importance and significance of diabetes. It would be helpful to have the work of the Collaborative supported by such messaging.
- It would be useful to discuss aspects of clinical practice guidelines at an upcoming workshop, particularly in terms of what elements of the guidelines could potentially be a focus for practices in terms of the changes they may choose to introduce.
- There is interest in having an information session on how to do patient engagement over the internet.

Meeting Feedback

At the end of the meeting, participants were asked to provide feedback about the workshop and identify required future supports and potential topics for future Quality Collaborative meetings.

In response to a question about whether, after the meeting, they have any unanswered questions about the Quality Collaborative: Diabetes, participants answered the following:

- Lots, but I believe we should be able to answer them as we go on
- No
- Not today
- A few, mostly about process and evaluation. Have to take information back to NECHC team to get their feedback
- Still not sure how this is going to work
- How will our results affect "the system"?
- Not sure how I will implement this into my practice, not clear yet how it will work. I am sure the workshop will help answer these questions
- No

In response to a question about what they believe are the most important things that need to happen to make the Quality Collaborative: Diabetes a success, participants offered the following:

- Staying in contact
- Commitment
- Constant communication
- Effective communication; time
- Practice support; printing support
- Still not sure how this initiative will work in my practice
- Flexibility – ease of implementation

When asked to share any feedback about the meeting, participants responded:

- I feel that most changes we expect to happen are focused on patient participation and collaboration (?) rather than us, doctors, to make changes in the way we manage our patients – the gap seems to be patient collaboration and not using the available resources
- Well organized
- Provider-centered initiative; possible patient perspective/input
- Some lack of clarity between individual staff members about role, purpose –evolving–
- Exciting collaborative to be a part of. I think it has a lot of potential to improve care

Appendix 1 - Agenda

Quality Collaborative: Diabetes-Workshop Orientation

March 3, 2011
9:00 am to 12:00 pm

East Dartmouth Community Centre
Meeting Rooms A, B, and C

50 Caledonia Road, Dartmouth, NS

1. Welcome and Introductions
2. Why a Diabetes Collaborative?
3. How It Will Work: Overview of Process and Structure for the Collaborative
4. Break
5. Data Collection to Support the Collaborative
6. Logistics: CME Credits, Compensation and Expenses
7. Feedback
8. Next Steps and Closing Remarks
9. Networking Lunch (provided)