

IMPROVING CARE

FOR PEOPLE WITH
DIABETES

WORKSHOP 1 MEETING PROCEEDINGS REPORT

QUALITY COLLABORATIVE
DIABETES



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Quality Collaborative: Diabetes Workshop 1 Meeting Proceedings Report
Prepared by Pyra Management Consulting Services Inc. April 2011.

Introduction

The Quality Collaborative: Diabetes is a new learn by doing initiative for some family physician practices within Capital Health. The purpose of the initiative is to improve care and outcomes for patients living with diabetes in participating practices. One of the ways Capital Health is supporting quality improvement is through regular workshops where participants can come together to learn as a group and from each other. On April 5, 2011, the Diabetes Collaborative coordinated by Capital Health met for the second time in East Dartmouth. The purpose of the meeting was to:

- Increase understanding of the Chronic Care Model (CCM) and its applicability to family practice;
- Explore the current level of practice alignment with the various components of CCM;
- Enable family practices to set a practice improvement goal based on Collaborative AIMS and Measures;
- Increase understanding of the Plan, Do, Study, Act (PDSA) cycle and how to apply the methodology;
- Enable participants to develop a first step PDSA action plan;
- Increase understanding about the importance of data collection, critical attributes and success factors for a practice registry and project exploration for data collection; and
- Enable family practices to develop a first steps plan to flag patients with diabetes in the practice, and set up a practice registry.

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.

Chronic Care Model (CCM)

Lynn Edwards, Director of Primary Health Care, presented an overview of the CCM. Highlights from the presentation included:

- Chronic illness care means transferring from a system that is essentially reactive to one that is proactive and focused on keeping a person as healthy as possible.
- The CCM offers a framework to help guide change in practice, not only in diabetes, but across all chronic conditions.
- CCM is a multidimensional solution to complex problems.

Key success factors identified by practices that have effectively used the CCM to successfully impact chronic disease outcomes include:

- Knowing the practice population and its characteristics;
- Multidisciplinary teams with very clear roles; and
- Connection to community.

Some of the points raised by participants about the CCM included:

- The privacy laws in Nova Scotia make it challenging sometimes to work with other practices. It is difficult to share patient information.
- One physician asked the following question to all patients with diabetes that he has seen since the first meeting of the Collaborative: “Who is responsible for managing your diabetes?” Eighty percent of respondents said the physician is responsible, underlining the importance of culture change among the population re: self-management,

and the fact that specialists are not always needed to manage their care. Participants wondered how best to change perception among patients and family practitioners that specialists are not always required to manage care.

- Patient reminders are an interesting dilemma: we have a responsibility to care for our patients and reminders are part of this care (as well as ensuring system resources are used well); however we need to enable patients to take control of their health and does reminding them re: appointments absolve them of responsibility for their own health? There needs to be a balance.
- Finding the balance for responsibility for health will always be a challenge; ultimately it is about shared responsibility.

Practice Pre-Survey

One of the items being measured through the Collaborative is the extent to which we are able to increase provider confidence in providing diabetes care. The pre-survey for physicians looks at the elements of practices now as they relate to the CCM. It will be completed again in 18 months to see what changes have happened. The survey was also used as an opportunity to reflect on the extent to which individual participating practices align with elements of the CCM.

All participants from practices completed the Practice Pre-Survey.

Reflections on Diabetes Care

Participants worked in two small discussion groups to discuss the following questions:

1. What is the current state of practice in care for people with diabetes in relation to the CCM?
2. How can we improve diabetes care in relation to the CCM?

After the small group discussion, highlights of the discussion were shared with the entire group. The following is a summary of key points made about how diabetes care can be improved:

- Common patient flow sheet.
- Better communication between providers, doctors, and diabetes centre through a passport, like prenatal records for example.
- Use and promote 811 system where patients can find out about resources in the community to support self-management.
- Question re: District Department of Family Practice (DDFP) – how do we find out about new initiatives, resource list available online?
- External environmental scan about health policies/decisions might be useful to help us understand how we can align our practice to meet the intentions of the policies.
- Internal – environmental scan would be useful to identify for us the resources/supports available to diabetics (e.g. financial, services).
- Very limited resources exist to manage diabetes proactively.
- Patients are very overwhelmed.
- We need “diabetes anonymous” like alcoholics anonymous to provide support for people with diabetes.

- 3 day programs are not useful – too overwhelming, unattractive to patients (other participants noted that 3 day programs are no longer available).
- Patients don't believe how serious diabetes is. Maybe we need to change language to “malignant diabetes” so they truly understand the potential harms of the disease.
- Using a Facebook page for the community associated with the practice could enable an option for providing education, and enabling patients to share their perspectives on their diabetes.

The detailed notes from each of the small groups is in Appendix 2.

Practice Registry and Data Collection to Support the Collaborative

Christine Tompkins presented an overview of the consolidated Registry that will be used by the Collaborative. Highlights of the presentation include:

- The purpose of the Registry is quality improvement, to see if there are trends in the various measures.
- All practices will collect data that will contribute to the collective Registry for the Collaborative.
- Data re: the AIMS and Measures will be collected from all practices.
- Data submission from practices to CDHA will happen during the time frame of June 2011 to December 2012.
- CDHA does not want to be prescriptive about the type of data collected, because it is important to allow practices to innovate and then share. Ultimately practices need to pre-survey and post-survey to determine if care for patients has improved, and there is a need to collect data around the AIMS and Measures. We need to find the balance between being flexible and prescriptive.
- Workflow sheet – there is a template, or adapt your own.
- Don't need patient identifying information before sending in the data to CDHA.
- Regular feedback about the data will be provided back to participants.
- CDHA needs practices to submit new measures for patients seen on a monthly basis, either through flow sheets, an EMR template, Excel spreadsheet, etc.

The Privacy Impact Assessment for the Collaborative concluded we don't need informed consent to collect data from the Registry. However, practices need to make sure patients are aware of the Diabetes Collaborative. Practice posters and brochures for patient awareness are available (patients can opt out of the Registry if they choose).

Care Plan

During the discussion about the Registry, a discussion about care plans was held. It was agreed that it would be useful for the participants in the Collaborative to have a common tool for care plans.

Dalhousie Family Medical Experience

Dr. Fred Burge from Dalhousie Family Medicine provided an overview of how his practice group has been developing a patient registry. Highlights from the presentation include:

- Dalhousie Family Medicine has been looking at quality for a number of years, and over the past 6 months, has been building a practice registry.

- It is important to build capacity within the practice to build and maintain the Registry, and not just rely on one champion.
- A registry is a living thing; it is always changing.
- First step was to identify who are the diabetics in a practice of 2000. The team was surprised at how small the number was.
- The team then verified that each person on the list was actually a current patient with diabetes (this cleaning of the list took a few months).
- After cleaning, the team created a “patient type” in Practimax called “diabetic”. This group of patients is their diabetic registry.
- Another option would be to build the registry as you see patients with diabetes.
- In the Nightingale system, it is possible to create a clinical group based on diagnostic codes, and can get a printed report (but not an exported file in Nightingale).
- Once the patient group is identified, decide what changes you want to implement with that group. Then add additional clinical data elements (such as foot care or ophthalmology) related to those changes. The Collaborative will help with this aspect of data entry/reporting.
- Key to success was creating a “cue” to remind practitioners to continue to update the Registry.

Plan, Do, Study, Act (PDSA)

Dr. Rick Gibson presented the PDSA cycle and provided concrete examples of how it will be used by the Collaborative. Highlights from the presentation include:

- You have to know what you are trying to accomplish and how you will know you have made a change.
- The PDSA cycle enables you to test new ideas, see if they work, discard ideas that don’t work and continue to implement and share ideas that do work.
- Using the PDSA cycle, practices will make a change in their practice; something they have control over in the short term. Something that can be tried in the short term and changed if it does not work.
- It is expected that some of the changes implemented will not work.
- If you don’t see some failures, you are not pushing the envelope far enough.
- Over the course of the Collaborative, practices will develop and implement many PDSAs. Keep them small; implement them often.
- This process is about being an innovator.
- Pilot testing a change is useful before implementation.
- It is important to share with each other what we have learned about what works in our practice.

Collaborative Logistics

At the end of the day, Collaborative Project Manager Lynn Lowe reviewed logistics related to the Collaborative, these include:

Binders: Margie will help ensure binders are kept up to date with new materials.

PDSA: Expect you will need to create several PDSAs before the next meeting. It will be great to share learnings from PDSAs at next meeting so please come prepared to share. Another tool that other Collaboratives have used successfully is a story board. This is a presentation to the group in whatever format you like about a change you have implemented.

Patient Survey: The purpose of the patient survey is for evaluating the Collaborative. It needs to be distributed as soon as possible. A group of interested people will get together to finalize the survey. Those interested in participating should let Lynn Lowe know. The working group will fine tune the language, bring the literacy level down, and make it shorter.

Care plan: A Working Group will develop a template for the care plan for the Collaborative, as well as potentially a diabetes passport for communicating among care providers across the system. Collaborative members interested in participating in this Working Group should contact Lynn Lowe.

Practice Agreement: The practice agreement outlines the parameters of participating in the Collaborative. Participants were asked to either sign it today or sign and bring to the second meeting.

April 28 CME Diabetes Event: The Collaborative will cover cost of participating. Staff will find a way to share details from the April 28th CME event for those who cannot attend.

CME Credits: Today's session is accredited for 6 "C" category MainPro Credits. In order to qualify, participants need to complete the post reflective exercise form and return it to Lynn Lowe, who will then send a confirmation to participants stating that the requirements for the credits have been met.

Next Meeting: Obesity Clinic Space in former West End Mall (now called Mumford Professional Centre) on June 22, 2011, 2nd floor, free parking.

Next Steps: Get in touch with the Capital Health team with any questions or concerns. Margie will connect with each practice to set up appointments to provide support as necessary.

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 what supports participants think they will need to accomplish their PDSA plan, participants identified the following:

- Technical support from Nightingale (4)
- Time (4)
- Financial support to recruit data entry professionals; knowledge and information from lab database about patients
- Enthusiasm
- Review of our EMR capabilities
- Regular access to practice facilitator; collaboration with DMC

- I think it will be important to have feedback on the specificity and measurability of thoughts/goals set

Topics suggested for future meetings included:

- Involving whole practice in the implementation and ongoing workflow of the new processes
- “Process indicators”
- Motivational interviewing
- Review PDSA; different registries
- Success/challenges with creating registry and “do” of PDSA
- Psychopathology in diabetes
- Need identification of resources available in CDHA to support patient care in diabetes (internal scan); Need external scan re: health promotion disease prevention priorities for the province
- Data storage; computer/EMR practical tips
- Use of IT in establishing database as well as populating CDM flow sheets; improving patient compliance
- Patient education material

When asked what went well about today’s meeting, participants offered the following:

- Good interactive work (2); well facilitated; appreciate binder handouts
- Good lunch (3)
- Good Firm plan
- Opportunity to discuss plan with team members
- Location
- Outline; realistic agenda
- Break-out sessions
- Cross fertilization of ideas
- Excellent flow and time keeping
- Identifying scope of project; Wow!

In terms of suggestions for future meetings, the following were offered:

- More stretching and moving
- Didactic/PowerPoint presentations could be condensed to a few practical slides; provide more opportunity for group discussion
- More story boards like Dr. Burge; maybe Mike Wadden for us Nightingale users
- Hard copies of AIMS/Measures and CCM model (e.g. on back of agenda); when discussing Registry hold separate discussion for groups using paper and groups using EMR
- Provide copies of documentation and overheads before presentation; use adult education techniques; staff could circulate more and support discussions or address questions
- Try to avoid multiple worksheets, the discussion and group work is more valuable

Appendix 1 - Agenda

Workshop 1

April 5, 2011

9:00 am to 4:00 pm

East Dartmouth Community Centre
Meeting Rooms A, B and C

50 Caledonia Road, Dartmouth, NS

1. Welcome and Introductions
2. Pre-survey
3. Chronic Care Model: Overview and Linkage to Model for Improvement
4. Break
5. Goal-setting exercise
6. Lunch
7. Practice Registry and Data Collection to Support the Collaborative
8. Practice Registry Exercise
9. Break
10. Plan-Do-Study-Act (PDSA)
11. PDSA exercise
12. Next Steps and Closing Remarks

Appendix 2 – Notes From Facilitators of Small Groups

Group 1

- Current working relationship-connection to CCM-in one work-abysmal
- Work in silos even when we work same location
- Traditional model-funding system supports silo working/partly to blame
- Physician paying for nurse, space-using space for non-traditional care/non-billable care challenging
- Can't shadow bill unless doc eyeballs patient-no compensation for time facilitating care relationships
- Need internal environmental scan to know what supports are available/not available (from DMCs for example)
- Need external scan of policy/strategies/external resources
- CDM support – need to conference with 3rd person??
- Expectation in the patient community is that there is a relationship
- Missing link – no collaboration with the collaborators e.g. DMC giving patients information and not sharing this with physician practices
- Total disconnect/lack of communication with current collaborators
- One practice shared they have a satellite diabetes clinic that comes to their practice every second week – write in chart – enables direct communication
- Need to consider pre-diabetes as – ¾ of Duffus patients – nothing to support them currently
- Need to shift resources – no incentive to manage metabolic syndrome
- What about instituting a public health approach where diabetes educators visit people in their home – people need nutrition/cooking/label-reading/shopping advice
- Need community collaboration to address needs of system
- Need easily accessible list of resources available
- 1-800/211 linked to DMCs/community resources
- Identified a role for DDFP in supporting practices to be aware of resources
- Suggestion that if there was an electronic list – doc could enter postal code and print off handy list of resources to give patients
- Docs have great difficulty in knowing what resources are available
- Need parts of the system communicating with each other – health passport/health journey – interactive to instantly engage patients as partners and help collaborators be informed
- Immediate engagement around current prenatal – share document with family/father
- Health journal immediately becomes a partnership if there are part patients need to fill out (i.e. physical activity)
- Key point is that it enables communication among providers
- Care plan – informed and potentially in agreement with others – next best thing to co-location
- Duffus starting to use DEC checklist

- Would like a copy to help in the development of a passport so that they give
- Judy mentioned lady who works at RCP as someone to connect with – data analyst – didn't remember name
- Folks want to know how their success related to others across the country

Group 2

What is the current state of practice in care for people with diabetes in relation to the Chronic Care Model?

- Don't know yet
- See the “bigger picture” (i.e. Capital Health). Think it's fragmented
- Focused on activity – limited resources to manage proactivity
- Patients are overwhelmed... Possible Diabetes Anonymous
- Not informed and activated – looking to provider (many social factors impacting this)
- 3-day programs – needs of small group
- Lack of follow up after formal sessions – also typed synopsis
- System is focused on “activity”... Not preventative
- Money should be focused on exercise programs, nutrition programs in schools