Improving care

for people with
Diabetes

Workshop 3
Meeting Proceedings Report

Quality Collaborative
Diabetes

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

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Quality Collaborative: Diabetes Workshop 1 Meeting Proceedings Report
Prepared by Pyra Management Consulting Services Inc. October 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 October 6, 2011, the Diabetes Collaborative coordinated by Capital Health met for the fourth time in Halifax (the orientation meeting was held in March, workshop 1 was held in April, and workshop 2 was held in June). The purposes of the meeting were to:

1. Briefly review and reinforce key messages from previous sessions;
2. Increase peer sharing and learning of Collaborative experiences. For example, share experiences (successes, challenges, lessons learned) on data collection, PDSAs, practice improvements.
3. Increase participant understanding of Self-Management Support (SMS) and their facility and ease in engaging in SMS with their patients.
4. Increase participant awareness and understanding of the patient experience with care.
5. Increase participant ability to improve patient experience with care in the practice setting.
6. Gather feedback on the baseline report.
7. Share CIHI developments on the trending report and gather input on key elements of the report.

This report provides an overview of proceedings from workshop 3. Slides from the presentations given at the meeting are available by contacting qualitycollaborative@cdha.nshealth.ca.

Looking Back

The meeting began with a presentation from Lynn Lowe from Capital Health that reviewed the Collaborative's progress to date, including:

- Exploration at the first Collaborative workshop of the chronic care model, model for practice improvement, practice registry and completion of a survey of participating physicians.
- Action period 1, during which time participating providers:
  - Developed their practice registries;
  - Submitted baseline data;
  - Identified/refined practice goals(s);
  - Prepared to undertake first PDSA;
  - Distributed patient surveys;
  - Connected with the practice facilitator; and
  - Prepared workshop storyboards for workshop 2.
- Collaborative workshop 2 that focussed on evidence based care, self management support, increasing understanding about the PDSA cycle and information about QIIP in Ontario.
- Action period 2, during which time participating providers:
  - Planned and implemented their first PDSA;
  - Connected again with the Practice Facilitator;
  - Collected patient surveys; and
  - Prepared workshop storyboards for workshop 3.

Lynn noted that 128 patient surveys have been returned, and it is expected that practice level data will be shared in late fall 2011.

Storyboard: Duffus Team

The practice team at Duffus shared their experiences in learning about how patients with diabetes dispose of sharps (i.e. syringes, lancets and pen needles). The team learned that most patients with diabetes do not have a sharps disposal container, and therefore do not dispose of sharps safely. The team contacted 20 pharmacies to inquire about their practice in providing sharps containers and discovered there is inconsistent practice among pharmacies: some provide containers only to new diabetics, some provide containers only when asked and some do not provide them at all.

The team discovered that in 2000, the Canadian Diabetes Association and the Pharmacy Association of Nova Scotia signed a Memorandum of Understanding (MOU) to collaboratively implement a program for safe sharps in residential settings, however, much of what is outlined in the MOU is not being implemented. There is also an agreement that exists between the Pharmacy Association of Nova Scotia and the Resource Recovery Fund that enables patients with diabetes to get free sharps containers from pharmacists at no cost to pharmacists and patients with diabetes. The practitioners at Duffus are now making it a practice to ask their patients with diabetes how they safely dispose of sharps and informing them that they can ask their pharmacist for a free disposal container.

Peer Learning and Discussion

A portion of the meeting agenda was dedicated to sharing among the Collaborative members and discussing common issues and brainstorming solutions. Each topic discussed is briefly summarized below.

Diabetes Management Centre
There were a number of issues discussed about the relationship between the Diabetes Management Centre and practices, including:

- Lack of clarity about the role of the Diabetes Management Centre in providing foot exams, dietary counselling and eye exams;
- Lack of documentation about same; and
- Lack of clear communication via the Diabetes Management Centre form. There needs to be less narrative and clearer indication of what the Centre is doing in terms of care. Goals of patient care should also be on the form.

Action: Margie will follow up with the Diabetes Management Centre to inquire about the status of revision of the form used by the Centre and to request that the District Department of Family Practice be able to provide feedback on the draft revised form.

Communication with Pharmacies
It was observed that it is not always easy to have conversations with pharmacists, because patients often use many different pharmacists. It was noted that patient education is not always happening at the pharmacy and it would be helpful to have a pharmacist join the Collaborative so there could be ongoing discussion about the roles of different

providers in communicating with patients and with each other.

Action: Lynn will invite a few community pharmacists to join the next meeting. Key questions for discussion with the pharmacists will be:

- How are they educating patients about diabetic medication?
- What other education do they offer and is there a cost?
- Their experience in working with patients with diabetes.

Diabetes Screening for Obese Youth

Participants spent considerable time discussing the need for screening obese children and youth for diabetes. There does not appear to be any systematic way that this is happening. Ideas were generated about ways to reach obese children through the adults that practitioners see more often in their offices, such as education about child nutrition as part of Well Woman clinics and using more signage in offices to promote physical activity and nutrition.

It was suggested that Public Health Nurses could have a role in diabetes screening, and that there should be a physician fee code to enable diabetic screening for children and youth.

Actions:

- Cindy will speak with a colleague who is a public health nurse to learn more about what public health nurses are or could be doing about screening.
- Lynn will determine the process required to request the fee code committee at Doctors Nova Scotia to implement a new fee code for diabetic screening.
- Lynn will circulate the link for the recent online survey about childhood obesity being conducted in Nova Scotia.
- All members will consider developing a PDSA to actively screen obese children and youth for diabetes to identify the number of youth with the potential for diabetes.

Supporting Patients to Make Change

Participants shared ideas about how to support patients in making changes. Suggestions included:

- Encourage them to focus on one small change;
- Get them to be really specific about the change they want to make;
- "Star" charts for positive reinforcement;
- Write the change as a prescription; and
- Create a wall of success in the clinic for patients who want to voluntarily share their positive experiences.

Relationships/Communication with Specialists

Participants discussed that it is not always clear why specialists continue to follow patients when the treatment regimen could be adequately managed by the family physician. It was suggested that it might be helpful to have specialists come to the next meeting to discuss the focus of care for patients with diabetes.

Action: Lynn will approach adult and paediatric specialists to invite them to the next meeting to discuss:

- The type of care being provided by specialists;
- How specialists see their role and responsibilities in the continuum of care for patients with diabetes; and
- Identify what specialists need from family physicians in order to provide optimal care.

Self-Management Support

Dr. Michael Vallis returned to the Collaborative to build on the information provided at the last meeting. He facilitated dialogue about practical application of self management support theory. He identified that the following behaviour change counselling skills are needed by family physicians:

- Relationship skills: establishing a change base relationship using motivational interviewing;
- Motivational skills: getting to the behaviour; and
- Emotion management skills: helping to maintain the behaviour.

The group was asked to consider their response to a patient who says: "I wasn't able to do what we agreed on, but I was able to ...". The most common response is to say "good for you" to positively re-enforce what was accomplished. However, when you use re-enforcement, you get more of the same, in other words, more of the patient not doing what had been agreed. A better approach is to inquire about why they were not able to do what was agreed upon. This enables the patient to take responsibility for what they did not do.

There are three aspects to a professional change-based relationship:

- Bond alliance: Creating a bond with patients tends to be the aspect that practitioners are best at, however, it is important not to allow the bond component to dominate the other two aspects.
- Task: The relationship is about working on specific tasks to achieve a goal.
- Goal: There must be a common goal.

It is very important to re-enforce change behaviour that is associated with the completion of tasks directed toward achieving the goal. Re-enforcing other behaviours addresses the bond alliance aspect of the change-based relationship but not the other two important aspects.

The group also discussed motivational interviewing at some length, focussing in particular on the difference between emotional empathy ("how do you feel") and expressing empathy related to the behaviour. By expressing empathy, practitioners are trying to understand why the behaviour exists. There are two stages of expressing empathy:

- Summarize and feedback to the patient what they told you (do not validate feelings, but rather validate the patient's theory about why they won't change); and
- Invite a conversation about another option/reason for change.

Dr. Vallis identified that many practitioners have more competence than confidence with supporting behaviour change. It might be possible to get better behaviour change outcomes if practitioners organize their skills into a framework so that there is clarity about what type of technique is being used in patient relationships. Being clear about the strategy that is being used to support change will help guide the statements that are used with patients.

Patient Experience

Joyce Riley is a person living with diabetes, who shared her life experiences with the group to help shine more light on the patient's perspective of providing care to patients with diabetes. Joyce's key messages included:

- Having diabetes is a way of life.
- Family physicians have to treat a person's diabetes in the larger context of the individual's life.
- It is important to make it comfortable for people to ask questions.

- Ask patients "what is working for you?"
- Remove the fear as much as possible.
- Help people understand their disease.
- Promote self awareness of body reactions.
- Encourage patients to write down their questions for their doctor.

Data Update

Lynn provided an update on the data collection process for the Collaborative and invited feedback about the baseline data report. Participants discussed and agreed that for future Collaboratives, it should be mandatory for all practices to collect baseline data for the same period to promote data consistency and better enable comparisons.

It was suggested that the final physician survey for the Collaborative should include a component for physicians to share key learnings from their participation in the Collaborative. It was noted that PDSA templates should also capture key learnings.

Action: Lynn will circulate and electronic copy of the PDSA template to all participants; Margie will provide a hard copy during her next practice visits.

Lynn explained that the Collaborative is exploring a potential relationship with the Canadian Institute of Health Information (CIHI). CIHI is interested in providing trending reports on a quarterly basis. Capital Health and CIHI are currently exploring the possibility of a data sharing agreement. Participants agreed that there is merit in partnering with CIHI.

Action: Lynn will organize a teleconference for all participants at the end of October to discuss the implications of working with CIHI.

Looking Ahead

Lynn briefly outlined the plans for practices during Action period 3, which include:

- Connecting with the practice facilitator;
- Submitting monthly measures;
- Reviewing patient survey reports and trending reports when available;
- Undertaking small practice improvement changes documented on PDSA templates; and
- Preparing storyboards for workshop 4.

The next workshop is scheduled for February 21, 2012.