Improving care

for people with Diabetes

Workshop 4
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. March 2012.

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 February 21, 2012, the Diabetes Collaborative coordinated by Capital Health met for the fifth time in Halifax (the orientation meeting was held in March, workshop 1 was held in April, workshop 2 was held in June, and workshop 3 was held in October). The purposes of the meeting were to:

1. Briefly review and reinforce key messages from previous sessions;
2. Increase participant understanding of the care pathway (and related communication to family physicians) of clients of the Diabetes Management Centres (DMCs), enhance mutual understanding and explore how the DMCs and family practice can work together/ communicate to ensure optimal patient care.
3. Facilitate peer to peer discussion on PDSAs, improvement activities and other activities related to the Quality Collaborative or improving care for patients with diabetes
4. Increase participant understanding of Self-Management Support (SMS) and their facility and ease in engaging in SMS with their patients.
5. Increase participant understanding of best practice for the screening and treatment of children and youth to prevent the development of diabetes.
6. Gather feedback on participant experience with the Quality Collaborative: Diabetes.

This report provides an overview of proceedings from workshop 4. Slides from the presentations given at the meeting are available by contacting qualitycollaborative@cdha.nshealth.ca.

Storyboard: Hants Shore Community Health Centre

The meeting began with a presentation from Dr. Judy Kazimirski about the Hants Shore Community Health Centre. The centre was started in the mid-1980's by the community, and it offers primary medical care services as well as many other community health promotion initiatives. Since beginning participation in the Collaborative, the team has moved from a traditional care model to a health coaching model that better enables patients to be internally motivated to make changes. The physicians keep a reminder on their desk to work within an "informed activated patient" model.

The centre has developed a number of partnerships, including one with the Windsor Vision Centre so that the physicians at the Centre get reports from eye doctors on their shared patients. This is a new way of working together. The Centre team also met with the Diabetes Management Centre in Windsor to identify better ways of sharing information. The Centre now has a foot care program offered by an accredited foot care practitioner. Dr. Kazimirski writes and article about diabetes in the monthly community newsletter, and the Centre participates in community events, such as an upcoming Women's Day information session, where they will discuss diabetes. The Diabetes Management Centre is coming to the Health Centre in April to offer a community presentation about diabetes.

In order to participate in the Collaborative, the team has had to implement a new charting process in order to identify and follow-up patients with diabetes (the centre is using a paper-based charting system), which seems to be working

well. The team has observed that patients are now more engaged in their care and are more aware of their health. The team believes the care they provide is more planned and deliberative, that there is better adherence to national guidelines, and better relations with partners.

Diabetes Management Centres

Lisa MacDonald provided a presentation about the Diabetes Management Centres (DMCs) and care pathways. Capital Health has been making numerous changes to the DMCs over the past year, including:

- Referrals are all triaged based on a set of parameters (e.g. A1C, recent events requiring modification of treatment)
- Centralized booking service to begin soon to help ease wait times in some areas;
- Changes are being made to the patient report form that physicians receive to simply and clarify information;
- Group education sessions have changed to begin with a self assessment form that is pre-circulated to participants for completion before attending the session, and group sessions have been shortened in duration;
- A new web site is being developed, which will have information for providers, patients and the public.

The group discussed what might be useful for inclusion on the web site. Ideas included:

- Forms that providers need to use in a format that can be filled out electronically (i.e. not PDF);
- Criteria for triage;
- One page tip sheets for patients (e.g. exercise, nutrition);
- Stories from patients.

Actions:

1. L. Lowe will distribute a copy of the patient self assessment form to Collaborative participants.
2. Participants with other ideas about things to include on the DMC's web site should e-mail Lisa MacDonald with their ideas.

Peer Sharing: PDSAs

The group discussed their experience with the Plan, Do, Study, Act (PDSA) cycles that were tested in this Collaborative. Most participants have not found the PDSA approach useful, viewing it instead as additional paperwork that is often filled out retrospectively to satisfy the reporting requirements of the Collaborative. Several participants suggested that the essence of the PDSA is what they do every day repeatedly and that stopping to write it down is artificial and slows them down.

The group explored what it is that has helped with changes in practices if not the PDSA. Having several team members focus on diabetes collaboratively has led to change in some practices. One participant noted that the stages of change model provided by Michael Vallis and their own health coach versus old model are the two tools that have led to a change in practice. One team noted that the only reason that they have been successful with PDSAs is because they have had nurses and residents to actually complete the document.

It was agreed that the tool might be more useful if it were worded to more specifically reflect the reality of physicians.

It was suggested that perhaps the Collaborative could try a PDSA form that includes the following questions:

- What is the problem?
- What change is proposed?
- What are the costs/benefits of the change?
- How are we going to measure it?
- What happened when we implemented the change?

It was noted that the outcomes of the Collaborative should be useful tools that could be used by other non-participating physicians in the future, and that perhaps there need to be more than one type of PDSA form.

Action:

3. L. Lowe will create a new PDSA form using the suggested questions and circulate it to the group to try.

Self Management Support

Dr. Michael Vallis returned to the group to continue dialogue and capacity building around self management support. He reviewed the change skills covered in previous workshops, as well as the importance and process of readiness assessment. A readiness assessment leads to one of three conclusions:

- Not ready – in which case the conversation with the patient focuses on understanding the behaviour
- Ambivalent – in which case the conversation focuses on expanding readiness to change by helping to identify meaningful reasons to change
- Ready – in which case the provider moves directly to behaviour modification techniques.

Dr. Vallis reminded the group that it takes between 2 and 5 years for people to consistently engage in new behaviours. He noted that as health care providers, it is important to remember that we need to understand that the most important goals in a patient – provider relationship are the patient's goals. Participants offered various scenarios as examples, and the group identified strategies for responses based on a self management support approach.

Type 2 Diabetes in Children and Youth

Dr. Beth Cummings from the IWK Health Centre (IWK) presented an overview of Type 2 diabetes in children and youth. Dr. Cummings noted that although she is seeing more patients with Type 2 diabetes that in the 1990s, she still would not consider it to be an epidemic. In 2010, the IWK saw 409 patients with Type 2 diabetes, and all of them were pubertal (youngest was 11 years old). Dr. Cummings reviewed the diabetes screening guidelines for children and youth, emphasizing that screening should not take place before age 10.

Action:

4. L. Lowe will share details about the personal wellness profile undertaken at the Community Health Teams and send the information to the group.

Dr. Cummings presented evidence about healthy eating recommendations for children and youth, including the importance of focusing beverage consumption in the early years on water or milk, with no more than 4 ounces of fruit juice per day. Recommendations for physical activity include no television before age 2, no televisions in bedrooms, maximum screen time of 1 to 2 hours per day, moderate to vigorous physical activity every day, and introduce activities early that can be of benefit throughout the life cycle.

In terms of screening, Dr. Cummings recommend annual blood pressure screening begin at age 3, and be interpreted based on age, height and gender tables. Lipid screening should be done at ages 9-11 and again at age 17-21. She emphasized the importance of addressing childhood obesity, noting that a 2003 survey found that one third of Nova Scotia children were overweight and 10% were obese.

Feedback on the Quality Collaborative Experience

In order to capture participant feedback on the experience of participating in the Collaborative thus far, Capital Health staff associated with the Collaborative left the workshop, and the facilitator asked the group to consider a number of reflective questions. Some participants left early and could not participate in this session, so the Collaborative Coordinator e-mailed them all to invite their responses to the questions.

What Has Worked Well and Not So Well

When asked what has worked well about the Collaborative, participants generally agreed that the ability to learn from a diversity of participants at the workshops was an aspect of the Collaborative that worked very well. The series of sessions with Dr. Vallis on building skills for self management support was seen as very useful, with a few participants noting that they have changed the way they practice to incorporate some of the concepts that were discussed in these sessions.

A few participants commented that having the Practice Facilitator visit was helpful in motivating them to move ahead; one participant said that they did not get much out of the visits from the Practice Facilitator.

As discussed in an earlier session in the workshop, the PDSA tool did not work well for most people. It was not seen as a tool to support change, but rather a paperwork burden. Two people felt that four full day workshops was too much of a demand upon their time, and that it might be better to condense the workshops to half days.

Supportive Conditions

When asked to identify what are the supportive conditions for active participation in a Collaborative such as this one, the following were identified:

- Being on an Alternative Payment/ Funding Plan;
- A practice nurse; one participant said there was no way they could have done this without a nurse
- A team makes it much easier; it would be difficult to do this by yourself
- Adequate administrative support, especially for data entry; and
- There needs to someone in the practice who will lead the practice's efforts. One participant suggested that there

needs to be both an administrative and a clinical lead within the practice.

Potential Improvements

Almost all participants agreed that they did not understand the level of commitment and effort required to participate in the Collaborative, especially related to data collection. It was noted that the two physicians who left the Collaborative in its early days left because of the work load required to participate. For future Collaboratives, it will be important to clearly articulate the expected effort. Also related to expectations, two participants said that they felt the Collaborative was supposed to have been more clinical in nature, but it has largely been an administrative exercise.

A few participants noted that there were hidden costs in participating, especially for fee for service physicians (e.g. cost of preparing letters to patients, staff time for stuffing envelopes, costs of mailing them out).

A few participants indicated that they do not feel like a model has been identified that could be shared with other practices in the future. They thought that this was the purpose of the Collaborative and they do not feel like a model that could be shared has been developed yet.

Finding a way to reduce the burden of data collection to identify and track patients was universally agreed as a necessary improvement for the future. The time required for data entry was flagged by many participants as a significant burden. It was suggested that the Collaborative should have identified an individual to assist with data collection within the practice. One person suggested that at least there should have been meetings set up with everyone on the same EMR system to provide direction on how to get the data out.

In terms of specific tools, participants suggested that having templates for flow sheets would have been helpful early in the Collaborative, as would making the templates available on-line. It was also suggested that clear and simple information sheets about Collaboratives and how they work might be useful. On-line chats instead of in-person workshops were suggested as a potential useful approach for the future.

Other Comments

Some participants are not sure that their participation in the Collaborative has changed their practice; others are sure that it has. One participant noted that the staff supporting the Collaborative have been very nice and very easy to deal with.

Feedback Forms

Ten participants completed and returned feedback forms at the end of the meeting. Results are listed below.

When asked what went well about the meeting, participants offered the following opinions:

- Dr. Michael Vallis and Dr. Beth Cummings (7 responses)
- Opportunities for discussion and sharing experiences (6 responses)
- Feedback session on PDSAs (2 responses)

- Stretch breaks
- All of it
- Information about DMC and how it works

In terms of suggestions for future meetings, the following were offered:
- Inviting endocrinologist (Dr. Tom Ransom)
- Include overview of data thus far
- Working lunch
- Opportunities for group to discuss cases

When participants were asked if they detected any bias in the presentations in favour or against any commercial product or service, none of the participants commented.

The following are participants' thoughts regarding their experience so far with the Quality Collaborative:
- Generally forcing practitioners to be more mindful of their care delivery and accountable because of reporting
- I love the diversity of participants and sharing of "stories"
- Very positive
- More admin support needed
- Collaborative helps with getting HCP motivation and buy in
- Offer multiple PDSA forms and review both reasons for HCP to use and the Collaborative benefits
- Instruct on PDSA use then 1-2 months later, re-instruct
- I think PDSA cycle works well to analyze and measure the data but I think what may not be successful is the outcome of better control of DM just by making changes in the physician's approach (considering time and cost)
- I think more fundamental changes country-wide need to be done

Nine of the ten respondents answered that they would attend if two more half-day workshops were offered in 2012; one participant said probably they would attend.