Success Factors in Swedish Diabetes Care

INSPIRATION FOR THE ADVANCEMENT OF DIABETES CARE
Introduction

Diabetes is a common disease that affects approximately one in twenty people. Of these, the majority (about 85 percent) have type 2 diabetes. Type 2 diabetes is a chronic disease that requires a major adjustment and changes in lifestyle for the patient. At the same time, there is also great potential to reduce the risk of complications, and in this, health care plays an important role.

The Swedish National Diabetes Register offers good access to information on the performance of various care units in key quality indicators. Analysis of data from the register shows differences in performance – something that indicates a potential to increase quality. Seven success factors can be seen in care units and county councils with particularly good performance results in diabetes care. The work of both the healthcare team and the county or regional management teams has an influence on the care that is provided, and the work of the various levels of the organizations is described in more detail in this publication.

This publication is intended for those who work with or in diabetes care, as a supervisor or in a healthcare team, as well as county council management teams that have a supporting role in quality development. Our hope is that you and your colleagues can find inspiration and benefit from these materials in your ongoing improvement initiatives. Discussion topics presented in this publication for each success factor can be used to support the dialogue about your own organization.
How have the success factors been identified?

The success factors have been identified through a comparative study examining the differences between counties in the composition of diabetes care for primary care patients with type 2 diabetes. The study describes factors that affect the quality of diabetes care, but does not claim to describe all relevant factors. Different counties have different strengths and different challenges, and some counties may not identify with all success factors.

The study was conducted in three stages

In the first stage, eight counties and ten primary care units were invited to participate in the study based on the results in the Swedish National Diabetes Register. These county councils were selected with the utmost care, and selection was guided by discussions with experts and analysis of quality indicators and background factors.

In the second stage, differences between counties and primary care units were identified through a combination of quantitative and qualitative analyses. The most important component was interviews with key people in each county. Over 80 interviews were conducted with representatives from primary care units, primary care management, central county council management, and political leaders.

In the third stage, a number of success factors were formulated based on the similarities and differences identified in interviews and analyses. Several of the success factors that emerged were also raised previously in the Swedish National Diabetes Register’s IQ project.

FIND OUT MORE

You can find out more about this study and its results in the Swedish report *Framgångsfaktorer i diabetesvården – En jämförande studie av diabetessvården i primärvård* (“Success Factors in Diabetes Care: A comparative study of diabetes treatment in primary care”, in Swedish.) The report is available in the Swedish Association of Local Authorities and Regions webshop at webbutik.skl.se.
Seven success factors

Seven success factors have been identified in care units with particularly good performance results. These success factors concern various parts of the organization. The work of both the care units and the supervisors, and the interaction between the various levels in the organization, has an effect on the care the patient receives and the results achieved.

The care unit’s work

Success factors 1-3 primarily concern the work of the care unit. What directly affects the patient is the actual care that is provided: how often and in what way the staff and the patient interact, the content of these encounters, and what effects these encounters have on the patient’s treatment and lifestyle.
The work of the supervisors

Success factors 3-6 primarily concern the work of the supervisors. The supervisor’s structures, processes and methods create different opportunities for the care unit’s work and thus indirectly affect the patient.

The work of the entire organization

Success factor 7 describes an overall success factor that concerns the work of the entire organization.

The figure above shows how these success factors affect different parts of the organization.
Focus on the patient’s targets

The diabetes team bases its encounters with the patient and its approaches concerning the patient’s treatment on a determination to, without unnecessary delay, achieve the best possible target values. Care units that have done this particularly well describe the following:

› A structured effort for care relationships, involving actively calling in the majority of patients with diabetes according to a predefined process.
› Goal-oriented drug therapy based on clear treatment stages (guidelines for when to modify drug therapy).
A structured process for care relationships, including actively calling in patients for appointments

Care units with good results adapt contact frequency based on the patient’s situation, with the goal of achieving the best possible values according to the individual circumstances of each patient. They plan their diabetes care and actively call in patients to appointments. One unit particularly emphasizes the benefits of a clear monitoring and appointment-booking list: “We plan throughout the year to achieve a steady workload and to make sure that no one is missed.”

Discussion topics:
▶ When and how are your patients called in for diabetes treatment?
▶ How do you adapt the appointments to the needs of specific patients?

Goal-oriented drug therapy with clear treatment stages

Treatment of risk factors (HbA1c, blood pressure, lipids) must be adapted to each individual patient, in different stages of the disease and in different life situations. At the same time, there is strong evidence of the value of secondary prevention through the monitoring of risk factors. Interviewed care units with particularly good results stress the importance of risk factors and goal-oriented drug treatment, noting that they move more quickly through the stages of treatment than other units. They also use clear treatment stages to do this. In many healthcare teams, diabetes nurses are involved in recommendations on the choice of drug treatment.

Discussion topics:
▶ How can you contribute to ensuring that the patient’s targets are reached as quickly as possible?
▶ How quickly do you move in and adjust drug treatment?

EXAMPLES FROM DIFFERENT HEALTHCARE PROVIDERS

Interviewed care providers at the Närhälsan Stora Högä medical center emphasize goal-oriented drug therapy. Metformin, for example, is started immediately at diagnosis. A number of employees stress the enormous educational importance this has beyond pure medical aspects; it conveys the message that there is a diagnosis that is being taken seriously and treated.
Targeted initiatives for patients with poor metabolic control

The care unit has a clear strategy for identifying patients with poor metabolic control in terms of risk factors, and targets particularly intensive initiatives to these patients. Care units that have done this particularly well describe the following:

- Early identification of patients with poor metabolic control.
- Appointment intervals adapted to the specific needs of each patient.
- Access to a diabetes nurse and work in teams.

Early identification of patients who need targeted initiatives

Strategies for identifying patients with poor metabolic control is something that was brought up in interviews with care units. One unit describes how its diabetes nurses keep track of which patients have poor metabolic control and ensure that these are called in more often. Two units describe how they specially identify and flag patients with poor metabolic control. Patients with poor metabolic (or non-existent) control are identified either in RAVE (a statistics and monitoring health record system for primary care) or discussed in special diabetes rounds.

Discussion topics:
- How are patients with poor metabolic control identified?
Appointment frequency is adapted to the individual needs of patients

Interviewed county councils and care units emphasize the importance of patients with poor metabolic control or special needs maintaining much more frequent contact with their care providers. One care unit with good results describes how “some patients need to come in ten times a year, and are of course allowed to do that!” Another unit describes an established routine for a higher appointment frequency for young patients with poor metabolic control. These patients have two appointments with nurses booked immediately upon detection.

**Discussion topics:**

- What types of support do you offer patients with poor metabolic control?
- How are appointments adapted for patients with poor metabolic control?

Access to a diabetes nurse and work in teams

All interviewed county councils and care units emphasize the diabetes nurse’s central role in diabetes treatment in primary care. The diabetes nurse is described as essential to enabling goal-oriented treatment and focus on patients with poor metabolic control, and helps ensure high availability and continuity for the patient. Care units with good results also often describe a diabetes team that meets and holds discussions with its patients.

**Discussion topics:**

- How do you work in your diabetes team?
- What skills and expertise do you have?
- What is the role of the diabetes nurse?
The unit’s results are always on the agenda

Care unit management maintains a dialogue with staff on the unit’s results, and discusses potential improvement measures related to monitoring and feedback of results. Care units that have done this particularly well describe the following:

› The staff is well informed of the unit’s results.
› Management has continuous dialogue with the staff on the unit’s results.
The staff is well informed of their results

Care units with good results are well aware of their results. In response to the question “What prompted you to start focused quality improvement initiatives?”, a number of interviewed units bring up the opportunity to monitor their own results in the Swedish National Diabetes Register. They describe how registration in the register led to an increased focus on and interest in the results. Discussion on the results has led to further discussion on challenges and improvement initiatives, which in turn has led to changed approaches.

Discussion topics:
- How are your results for diabetes care?
- How often do you monitor your results?

Management maintains a dialogue with staff on results

All interviewed care units with good results describe management that is engaged in diabetes care, reports back regularly on results, and leads a discussion on potential improvement measures with the staff. Discussion on the unit’s results may focus on patient groups (who are our patients with the greatest needs and how can we help them?), comparisons over time (can we see that our changed approaches have an effect over time?) and comparisons with other units (can we learn something from our neighboring units who, despite similar conditions, achieve better results?).

Discussion topics:
- How can the unit’s management ensure that all employees receive feedback on the results?
- What forums are used for dialogue with employees on the results?
Available knowledge and clear expectations

The supervisor communicates clear expectations with high ambitions, and provides knowledge and information to the care units in a way that is easy for the units to take in. County councils that have done this particularly well describe how:

- Easily accessible and comprehensible medical guidelines with clear recommendations.
- Firmly anchored guidelines.

Success factor 4
Easily accessible and clear guidelines

County councils with good results all have guidelines that are clearer and more easily accessible. A majority of county councils with good results have guidelines shorter than ten pages. Interviews suggest that short and clear guidelines are often preferred because they are easy to use when meeting with patients.

Some differences in the guidelines are also seen in the medical content, particularly in the degree of clarity regarding drug treatment. The county council in Östergötland, which has clear recommendations regarding the use of medication, accepts a greater use of insulin than other county councils. Several care units with good results emphasize the importance of guidelines advocating an intensive drug treatment program.

Discussion topics:

 › Do you have guidelines and treatment programs for diabetes care?
 › Are these guidelines accessible and easy to understand?

Firmly anchored guidelines

Guidelines are only effective if they are used and followed. The likelihood of this increases if the guidelines, in addition to being easily accessible, also have a high degree of credibility in the care team. Interviewed representatives from county councils with good results show that a thorough anchoring process in connection with the development of new guidelines contributed to a high level of credibility.

Discussion topics:

 › How do you work to increase awareness of guidelines and care programs?

EXAMPLES FROM DIFFERENT HEALTHCARE PROVIDERS

Region Västra Götaland works actively with its guidelines. Here are some of the ways how:

 › Guidelines are developed on mandate from the healthcare director following a GAP and needs analysis.
 › Guidelines are consistently designed, so that the reader recognizes the concepts.
 › All regional guidelines and care programs are collected in a common portal.
 › Suggestions for new guidelines are sent for consultation to all administrations and a model is in place for anchoring.
Follow-up and feedback of results

The supervisor shows an interest in and follows up on the results (not just for the county council as a whole but also for the various organizations), maintains regular dialogue with the care units on their results, and uses feedback of the results to stimulate discussion on potential improvement measures. County councils that have done this particularly well describe how:

› The supervisor regularly reports back results to the care units and uses feedback as an opportunity for quality dialogue.
› The supervisor internally reports all of the care unit’s results, thereby stimulating a comparison between units.
Regular feedback to the care units

With increased coverage in registration and quality of data in quality registers such as the Swedish National Diabetes Register, there are better opportunities for health services to monitor results. County councils with good results describe a structured feedback of results to the healthcare units, sometimes linked to the regular monitoring of financial and production results. They emphasize feedback as something that contributes to improvements, and are increasingly using the feedback of the results as an opportunity for dialogue about quality with the care units.

Discussion topics:

› How do you monitor the organizations’ results in county council or regional management?
› Have you set any goals for diabetes care?
› How can you best maintain a dialogue with the care units about quality?

Internal reporting of the care units’ results

An active reminder of the unit’s own performance in comparison with other healthcare units in the county can stimulate reflections about their own care, and over time contribute to the leveling out of variations. All counties with good results describe an open disclosure of the performance of all care units that the units can use to compare themselves with one another.

Discussion topics:

› To what extent do you report comparisons between different care units?
› What would simplify such a comparison?

EXAMPLES FROM DIFFERENT HEALTHCARE PROVIDERS

In Region Västra Götaland, the care units can log in to the primary care database and see all of the units’ results for 13 selected diabetes indicators.

In Östergötland County Council and Sörmland County Council, the care units’ results are presented on annual Diabetes Days.

In Jönköping County Council, the results are openly reported once a year for medical advisers at care units and for the county council office, as well as on annual Diabetes Days.
The area is prioritized with long-term improvement initiatives

The supervisor has made a special effort in diabetes care (as one step in the clear prioritization of focus areas), and consistent and focused improvement efforts have been underway for a number of years and thus given the chance to achieve results. County councils that have done this particularly well describe how:

- Focus on diabetes, with political prioritization.
- Improvement efforts underway for a number of years.
Focus on the area of diabetes, with a foundation in political prioritization

Focused initiatives in one or more areas at a time increase the chances of achieving results. One example of a focused initiative is Region Västra Götaland’s investment in diabetes, which places particular focus on the practical implementation of the Swedish Board of Health and Welfare’s national guidelines. Among other initiatives, a “region mission” or “ownership mission” was approved in 2010, which describes regional goals, proposed measures, special initiatives and an analysis of the current situation. This was followed up by an implementation of newly developed local guidelines through a visiting tour of all primary care units, the inclusion of diabetes indicators in the regular follow-up work, and through links to financial compensation.

Discussion topics:
- Is diabetes a prioritized area for development?
- Are there political prioritizations in this area?
- To what extent is this a matter of urgency for you?

Consistent improvement initiatives over a longer period of time

Several county councils with good results have been invested in the area of diabetes for some time. One example is a long-standing initiative in Sörmland County Council, where in 2003 the diabetes council drafted a ten-year plan with goals and milestones for the progress it wished to see in diabetes care. Among other things, this involved a focus on diabetes coordinators.

Discussion topics:
- How do we ensure sustainability in your improvement initiatives?
Ownership for results and focus on prevention

The culture that permeates the entire organization places great importance on achieving improvements by learning by, and taking responsibility for, one’s own results, and stresses the importance of the prevention of secondary diseases and complications (sequelae). Organizations with particularly good results describe the following:

- Ownership for quality and results.
- Culture of following guidelines.
- Culture that has a strong focus on the prevention of sequelae.

Ownership for quality and results

A supervisor who takes ownership for the results of the care unit and a responsibility for, with all the tools at their disposal, actively supporting the unit’s quality improvement measures, has a greater likelihood of influencing the quality provided. Organizations with good results describe a higher degree of ownership for quality and the opportunity to affect the actual care provided.

Discussion topics:

- What is needed for you to feel ownership for quality and results?
Culture of following guidelines

County councils with good results describe a widespread culture of following guidelines. A tradition of standardization in diabetes care is described in Region Västra Götaland. “We have a long tradition of standardization in diabetes care, that everyone should do the same thing, and some of our good results can be attributed to this.”

Discussion topics:
› What is the culture in your organization regarding following guidelines?
› What are your organization’s strengths and weaknesses?

Prevention of sequelae

County councils with good results more often describe the importance of secondary prevention of sequelae and monitoring of risk factors, both in general and for diabetes in particular. A focus on quality of life and in certain cases skepticism that all patients will be able to reach their goals may of course be justified in many cases, but by and large, a higher level of acceptance of treatment goals is reflected in better achievement of these targets.

Discussion topics:
› What do you do to prevent sequelae?
› How do you view the balance between quality of life and treatment goals?

EXAMPLES FROM DIFFERENT HEALTHCARE PROVIDERS

Sörmland County Council has a diabetes coordinator who assists primary care at the request of the institutions. Political leaders describe how to hold discussions with officials after the year’s results from the Swedish National Diabetes Register have come out. Discussions are then conducted with the division manager on how to raise up units at the bottom, such as by referring to good examples.
The Swedish National Diabetes Register offers good access to information on the performance of various care units in key quality indicators. Improvements in results have been observed over time, but there are still large variations between county councils and care units, something that suggests a potential to increase quality.

Seven success factors have shown to be associated with the quality of diabetes care, and are presented in more detail in this publication. The publication is part of the work of the National Program Council for Diabetes to improve the quality of diabetes care and contribute to more knowledge-based, equitable and consistent care. The Program Council was established by the county councils and regions as a pilot area of the Swedish Association of Local Authorities and Regions.