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Evaluation of MSD's Facilitated Type 2 Diabetes Workshops

Det Nationale Institut
for Kommuners og Regioners
Analyse og Forskning

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List of abbreviations

MSD – Merck, Sharp and Dome (pharmaceuticals industry)
QI – Quality Improvement
WS – Workshops

1 Introduction

1.1 Background

Since 2009, MSD has conducted a large number of workshops for health care professionals in general practice in Denmark. The aims of the workshops are to optimise patient treatment, to present state of the art treatment procedures and to focus on workflow and division of labour within the clinic. A number of the workshops have focused on treatment of type 2 diabetes patients in general practice.

MSD has used questionnaires, which are filled in by participants at the end of each workshop, to evaluate the participant's satisfaction with the workshops. The results indicate that the participating GPs and their staff find the workshops useful as a starting point for improvement. Furthermore, the MSD facilitators have an impression that the workshops have a positive impact on the workflows, division of labour between staff and GPs and increased capacity and quality in the treatment of type 2 diabetes.

However, little is known about the workshops' actual impact on daily clinical practice among the participating practices and what drivers and barriers for change the participants' experience. Therefore, MSD has commissioned KORA to evaluate the workshops' impact on division of labour, workflows and adherence to clinical guidelines.

1.2 The workshops

MSD's Dialogue Workshop is an example of a formative implementation tool, used to promote internally driven development work. It a) allows general practices to assess their organisational capacity for type 2 diabetes treatment compared to existing guidelines with the help of a trained facilitator and b) aims at stimulating implementation of optimised workflows and procedures following the workshop. The workshop is based on principles from LEAN (KAIZEN light) and provides ready to implement procedures that cover the course of type 2 diabetes treatment in the clinic. The workshop concept includes two workshops. The first focuses on treatment of diagnosed patients in stabile course and the second (which is optional for participants of the first workshop) focuses on diagnosing and start-up of newly diagnosed patients.

MSD's workshop should be seen in context with the general development in general practice – where quality improvement (QI) is becoming increasingly important because the number of tasks, size and complexity of primary care units are growing, thereby introducing more staff and multidisciplinary teamwork (1-3). Also, there is some evidence that including staff in the decision making is positively correlated with higher quality of care (4, 5) because influence and shared knowledge bring encouragement and work satisfaction (6, 7). Due to these developments, interdisciplinary organisational assessment and goal setting as a means of QI are becoming an increasingly common and accepted feature in general practice (8-11).

1.3 The evaluation

MSD has commissioned KORA to evaluate the diabetes workshops. The overall aim of the evaluation is to assess how the workshops contribute to QI and organisational change in general practice. KORA has chosen to evaluate the workshops via an interview-based implementation study, an electronic survey and a time study in selected clinics.

The implementation study goes into detail with the participant's progression from workshop participation to achieved changes. The aims are to identify strengths and weaknesses in MSDs workshop concept along with perceived drivers and barriers for QI among the participants. The survey and the time study assess whether there has in fact been a change in organisation or other QI initiatives after the workshop. Also the survey is used to validate the findings from the qualitative implementation study.

The evaluation is conducted by senior research associate, MSc (Political Science) Martin Sandberg Buch and senior research associate, MSc (Econ), PhD Marie Kruse. The authors have no current or previous affiliations with the MSD and have no conflicting interests.

2 Evaluation design

2.1 Qualitative implementation study

2.1.1 Objectives and areas of investigation

The objectives of the implementation study are to examine how the practice teams worked on the goals set at the workshop and investigate barriers and drivers for reaching the agreed changes with regard to practice organisation. The objectives have been investigated via the themes presented in Box 1 below:

Box 1: Evaluation areas in the implementation study[1]

Perceived outcomes of participation in MSD's diabetes workshops ▪ As an instrument of assessment of organisational maturity and capacity to treat type 2 diabetes compared to existing guidelines ▪ As a starting point for formalisation of workflows and delegation of clinical tasks from GPs to staff ▪ Achieved changes and aspects that have influenced the implementation process
Participants perspectives on the workshops ▪ The role of the external facilitator and ready to implement procedures ▪ The workshop concepts, strengths and weaknesses compared with other QI initiatives targeted at general practice ▪ Participants suggestions for improvements of the workshop concept and dialogue concerning MSD's ideas for further development of the workshop concept

The above themes were explored in 12 semi-structured interviews each lasting between 20-90 minutes[2]. The interviews were conducted approximately four months after participation in MSD's workshops. All interviews were recorded digitally and the recordings have been used for analysis and quotation.

2.1.2 Sampling of cases and concerns of method

In order to strengthen the representativity of the sample, the eight participating practices were chosen by KORA from a larger sample of 24 practices that had participated in a workshop in 2012. The practices were chosen purposefully in order to ensure variation in terms of practice size[3] and facilitator as presented in Table 1. Table 1 also gives an overview of the informants who have participated in interviews and the number of workshops they have had:

---

1 The themes have been developed on the basis of similar evaluations, concerning QI in general practice (14-16) and dialogue with MSD.

2 Dependent on the number and type of informants – in general group interviews and interviews with GP's have lasted longer than solo interviews and interviews with staff.

3 We had an intention of including one or two large group practices, but it has not been possible to make arrangements in group practices with more than three GP's.

Table 1: Overview of the interview sample

	Practice 1	Practice 2	Practice 3	Practice 4	Practice 5	Practice 6	Practice 7	Practice 8
	Facilitator 1	**Facilitator 1**	**Facilitator 1**	**Facilitator 2**	**Facilitator 2**	**Facilitator 2**	**Facilitator 2**	**Facilitator 2**
Number of GPs	1	2	2	3	1	3	1	1
Composition of practice team	2 practice nurses and 1 secretary	1 secretary	1 secretary, 1 practice nurse and 1 bio analyst	1 secretary and 2 practice nurses	1 secretary, 1 practice nurse and 1 bio analyst	2 secretaries and 2 practice nurses	1 secretary and 1 practice nurse	1 secretary and 1 practice nurse
Participants in interview	1 GP and 1 nurse	2 GPs and 1 secretary	2 GPs and 1 nurse	1 GP and 2 practice nurses	1 GP and 1 bio analyst	3 GPs and 1 practice nurse	1 GP	1 GP

The interviews were planned with an intention to interview all GPs and all relevant staff in the sample, but as it can be seen in Table 1, lack of time combined with GPs who had forgotten the interview means that this goal has not been achieved in all clinics.

2.2 Survey and time study

The survey and time study were included in the evaluation in order to provide quantitative data for the evaluation. We chose to develop a questionnaire ourselves as we did not find any validated questionnaires focusing on QI and organisational change in general practice. We used an electronic survey in order to reach as many participants as possible.

The aim of the survey was to follow up on the workshop after six months to evaluate whether quality improvement and organisational changes had in fact been implemented.

2.2.1 Survey development

The purpose of the survey was to evaluate whether there had been any changes in the clinic as a result of the workshop. Therefore, the survey was conducted approximately six months after the first workshop for the clinic.

The survey questions were developed by KORA, and focused on the fulfilment of the overall aims of the workshops. The questionnaire was only validated internally before it was conducted. The questionnaire covered the following topics:

- Overall satisfaction with the workshop
- If the knowledge gained at the workshop had been implemented in the clinic
- Quantitative changes resulting from the workshop
- Qualitative changes resulting from the workshop
- Organisational changes resulting from the workshop
- If participants would have paid for participation if there had been a charge (willingness to pay).

The survey was conducted electronically, using the tool Survey Xact, developed by Rambøll. The entire sample of the respondents from January-December 2012 (N=210) was divided

according to the month of their workshop participation. The questionnaire was sent to them by e-mail on the 5th of the 6th month after their participation. A single reminder was sent to respondents who had not replied, on the 19th, i.e. two weeks after the first e-mail.

2.2.2 Survey content

The survey was introduced by letter, informing respondents of the topic of the questionnaire. The letter and questionnaire are enclosed in appendix 3. The first question of the questionnaire merely asks if the respondent participated in the workshop. This question is used as a filter in the analysis. Questions 2-16 are Likert-scale questions on the above topics, e.g. 'The Diabetes Dialogue Workshop focused on how the treatment of patients with type 2 diabetes can be organised in general practice. Was this information **useful** to you? Very much, a lot, not so much, not at all, don't know' (question 2).

The last question related to willingness to pay, here respondents were asked: 'In the last question please **imagine** that you hadn't participated in the workshop, but were offered participation at a **user charge**, paid by the clinic. Considering the knowledge you now have on the workshop, **would you participate**: At a user charge of up to DKK 1000 per participant; at a user charge of up to DKK 500 per participant; at a user charge of up to DKK 200 per participant? I would only participate if it was free of charge, I wouldn't participate regardless of fee, don't know'.

2.2.3 Survey conduction and reporting

72 respondents (34 per cent) responded to the questionnaire, 69 (33 per cent) completed the questionnaire. Two of the 69 respondents replied that they had not participated in the workshop. The results of the survey are reported below based on the 67 respondents who completed the questionnaire.

The first round of questionnaires was sent out in November 2012 and the last questionnaire was sent on June 5th 2013, and the last respondents were reminded on June 19th. The survey is reported descriptively by means of figures and tables in chapter 4.

2.2.4 Time study

The purpose of the time study was to identify possible shifts in the division of labour, as well as possible changes in the number of type 2 diabetes consultations, as a result of the WS. Hence, clinic schedules from a given month after WS participation, e.g. November 2012, were compared to schedules from the same month the previous year.

The time study was planned assuming that clinics would prepare printouts of schedules and send them to KORA. Unfortunately, this task has not been possible for the clinics, with one exception. In the case of two other clinics, the KORA investigator visited the clinic and printed the schedules, cut out personal identification numbers of patients and extracted the relevant information. A number of other clinics were contacted several times and asked to participate. However, they never returned the call, or were not able to provide the printouts.

Hence, the time study included only three clinics instead of, as originally planned, 5-10. Therefore, the results of the time study cannot be analysed using quantitative methods; instead, they are reported as illustrations of division of labour before and after WS participation.

2.3 Presentation of results

The presentation of results is structured as follows:

- Chapter 3 presents the results of the implementation study
- Chapter 4 describes and analyses the results of the survey among participants, as well as the results of the clinic time study.
- Chapter 5 summarises the results and concludes the report.

3 Results from the implementation study

This chapter presents the results from the implementation study. The presentation of data is structured according to the themes listed in paragraph 2.1 and there is a summary of the results.

3.1 Participants' assessment of the outcome from MSD's workshops

At the beginning of each interview, KORA's investigator asked the informants to summarise the outcomes from the clinics' participation in MSD's workshops. The outcomes mentioned by the informants from each clinic are summarised in Table 2 below and commented on in the following paragraphs:

Table 2: Overall outcome of eight clinics' participation in MSD's type 2 diabetes workshops

	Practice 1	Practice 2	Practice 3	Practice 4	Practice 5	Practice 6	Practice 7	Practice 8
Outcomes from MSD workshops	Better and shared overview of the diabetes treatment. Helps the nurse to remember the quarterly controls. The laminate is a useful checklist that helps to be more thorough in the consultations. Expects to have a more systematic focus on HcA1b.	GPs have recently taken over the clinic from two retiring GPs who did not comply with the guidelines. Therefore, there is much that needs to be changed and the workshops enabled an excellent dialogue about how the GPs wish to structure the treatment. Laminate/workshop gave a clear understanding of the ideal treatment regime – and how the clinic diverted from this. Expect the workshop to result in standardisation of the GP's routines and implementation of agreed changes.	Mainly confirmation that the practice were on the right track. The laminate is good – especially for training medicals – because the procedures and workflows between GPs and staff are not formalised. Removed redundant blood and urine tests	GP finds the workshop interesting and useful, but it has not had a noticeable impact on the GP's treatment. Nurses have gotten long needed standards for their quarterly controls. The nurses find the laminate very useful because they lack clear guidelines from the GPs. Removed redundant blood and urine tests	Great motivation for change: The mapping of tasks and workflows in the clinic made it very clear that the GP had too much to do, while the staff had too little. The workshop and the laminate helped to focus on implementation. Significant tasks have moved from GP to nurse and bio analyst and GP have been relieved. Staff is glad of new and more interesting tasks	Workshop has been impetus to write and implement formal instructions that regulate division of labour and guide consultations. Workshop provided opportunity for shared dialogue The workshop and the laminate helped to focus on implementation. GP's treatment and expectations of nurses are standardised. Responsibility has moved from GP to nurses. Standardised laboratory tests	Workshop has given a systematic treatment that concurs with guideline. Workflows and division of labour between GP and staff have been formalised. The laminate has been a great help – GP and nurse use it as checklist during most consultations. Significant tasks have moved from GP to nurse and GP has been relieved.	Better and shared overview of the diabetes treatment. Workflows and division of labour between GP and staff have been formalised. Better treatment and more systematic control. Significant tasks have moved from GP to nurses and GP has been relieved.

As Table 2 shows, all informants associate the workshops with positive outcomes that have a potential to change and improve their clinical practice. Firstly, the mapping of existing and future workflows and the laminated treatment regime are seen as a positive outcome in all clinics. An example of an immediate low hanging fruit that often seems to follow the workshop is the use of laboratory tests, which have been changed in three of the eight clinics as illustrated in the quotes below:

> *The workshop made it clear that the GPs used different blood tests although it was the same patients – that provided an opportunity to standardise.*
>
> *(GP practice six)*

> *The workshop made it clear that some of our tests where redundant, while others were missing. This has been changed after the workshop.*
>
> *(GP practice four)*

The interviews also leave a general impression that the workshops a) provide an accurate assessment of the practices' capacity for diabetes treatment compared with existing guidelines, b) promote a shared knowledge of the often implicit workflows in the practice team, c) present the results in a way that makes it easy to add/remove and exchange tasks between GPs and staff, and d) the laminate provided by MSD following the workshop is seen as a useful means of maintaining decisions as well as guidance for specific consultations.

However, Table 2 also shows variation in the expected outcome, as well as in the actual changes in the daily work that have been made upon participation: On one side, the workshops' actual impact on daily working routines remains limited in practice one to four. On the other side, informants from practice five to eight report that the workshops have been leverage for delegation to staff and resulted in significant changes in the daily working routines[4].

The following two paragraphs take a closer look at the individual perspectives on change given from the informants from each of the two groups of practices.

3.1.1 Perspectives from the practices that have not made changes

In practice one to four the reasons for not changing workflows and division of tasks, vary from practice to practice as presented below:

In practice one, the practice team has not talked about their participation in the workshop – and their picture/perspectives on the workshop were vague during the interview. The informants also assess that their diabetes treatment was already shared between GP and nurses in concurrence with existing recommendations. Although, there is no formal description of the workflows the GP has no plans for further formalisation of the workflows. Therefore, the only specific outcome is related to a minor change in the GP's use of lab tests.

[4] Please refer to chapter 4 for an assessment of whether the qualitative results – that the workshops have led to significant self-assessed changes in half of the participating clinics – are representative for the general outcome.

In practice two, the workshop has resulted in lots of plans for an improved treatment. However, lack of qualified nurses and a general lack of time have withheld the GPs from making formal changes in their treatment. However, the GPs do expect the implementation of the sentinel data capture module to result in the agreed formalisation of their treatment. The GPs have also considered employing a practice nurse, but so far, insecurity about the future fee structure combined with the economic strains that follow from buying a clinic, prevent this step.

In practice three, the informants said the workshop gave a confirmation that the workflows and clinical procedures were in concurrence with existing guidelines and recommendations for delegation of tasks from GPs to staff. This outcome is highly valued by the GPs, because the practice team has *worked hard to optimise the treatment of type 2 diabetes.*

In practice four, the one GP who participated in the interview, told that the main outcome from the workshops (the clinic has had two) is that delegation to staff and formalisation of workflows are difficult. During the interview with the GP KORA's investigator tried (without success) to obtain a more specific understanding of the barriers that kept the clinic from change. However, the interviewed nurses expressed a range of frustrations that may explain the lack of change: In the nurses' experience, what is holding the clinic back is a lack of shared commitment to agreed changes among the GPs. This means that some of the GPs stick to the old routines. The nurses also experience a lack of specific guidelines and general lack of sparring, making them unsure of their new tasks in the few consultations that have been delegated to them.

3.1.2 Perspectives from practices that have made substantial changes

In practice five to eight, the reasons for actual change in workflows and division of tasks vary from practice to practice as presented below:

In practice five, the GP and staff had experience from reorganising the treatment of COPD before participating in the MSD workshop. Also, the GP was very motivated for change, because she experienced working days of 13-14 hours while the staff lacked tasks. Finally, the practice has recently hired a new practice nurse from the diabetes outpatient clinic at a local hospital. According to the informants, these conditions have made the reorganisation of the treatment regime unproblematic and the informants state that the changes would have been made without participation in MSD's workshop. However, they also state that the workshop and laminated overview have had a very positive impact on the effectiveness of their implementation.

In practice six, the GPs and staff had also prepared for formalising the workflows prior to the workshop and the nurses have had some independent consultations for the past app. six years, but although the GPs and nurses agreed upon the need for further delegation and formalisation, nothing happened until the workshop. After the workshop, a GP and a nurse have used the laminate to prepare detailed workflows and guidelines for the diabetes treatment along with an information folder to the clinic's patients. The result of the work was presented and adjusted at a meeting with the rest of the practice and implemented immediately after. The informants expect that the changes would have been made without participation in MSD's workshop. However, they also emphasise that the workshop and laminated overview have had a very positive impact on the effectiveness of the implementation.

In practice seven, the GP tells that the treatment of type 2 diabetes used to be *"a little unsystematic with relation to which patients we saw and when we saw them".* Therefore, the GP and the nurse had a shared wish to formalise their co-corporation and workflows. However, the actual changes were displaced by a heavy workload. In this context, the MSD workshop has provided a written treatment regime that has helped the GP and his nurse to succeed with the intended changes. During the interview, the GP was not able to specify how the new workflows were implemented, but he expects that the implementation *"was easy because we were ready and the workshop gave us the overview and inspiration we needed to take the final steps".*

In practice eight, the mapping of tasks and workflows at the workshop, made it painfully clear to the GP *"that I at the same time was pulling the whole load in the diabetes treatment and such a heavy workload that I wasn't able to plan and implement the changes I wanted".* In this context, the GP experienced that the workshop provided a well-facilitated opportunity to describe a new workflow that delegated tasks to the practice nurse. The following implementation of the new workflows has been easy because *"the model was concrete and because we really wanted it".* In extension of this point, the GP also sees it as a great advantage that it was possible to design an individualised workflow that matched his clinic, although the point of departure was generic guidelines and recommendations.

3.1.3 Identified drivers and barriers for change

The perspectives from the practices that have not made/succeeded with change range from a) no time/no focus on change (practice one and two), b) no need to make changes (practice three) and c) what appears to be varied commitment to agreed changes among GPs and disagreement between GPs and nurses with regard to the level of sparring and support of the nurses' independent consultations (practice four).

The perspectives from the practices that have decided upon/succeeded with actual change are more coherent. The shared denominators for change mentioned by the informants from all four practices are a) too heavy workload for the GPs combined with an active wish on delegation of tasks from GPs to nurses prior to the workshop. In addition, the GPs from practice six underline a range of conditions that they see as important for change in a group practice: Firstly, the GPs shared vision of the diabetes treatment and their willingness to standardise the GPs routines has been a great help for the change process. Secondly, the shared responsibility between the two anchor persons (a nurse and a GP) has helped create a shared treatment regime and a sense of security and ownership in the whole practice team. Finally, some informants point to shared meetings and education in the new workflows as a means of change.

3.2 Perspectives on systematic and delegated follow up treatment

During the interviews, KORA's investigator asked all informants who had implemented actual changes (practice 5-8) about which effects they experienced in relation to the capacity to treat diabetes, the nurses working conditions. The main points are presented below:

The informant's general assessment is that the clinic's treatment of diabetes is more formalised and more systematic after implementing the changes that were agreed upon during the workshop. As illustrated in the quotes below (which are representative for practice five to eight) the informants associate these changes with increased quality:

We have become much better to remember the individual treatment goals and to follow up on these. We can also see a positive difference in the patients – because the nurses work much more with the patient's motivation to achieve changes in lifestyle and we refer more patients to patient education.

(GP from practice six)

We have a better success rate with the individual treatment goals that are set for each patient.

(GP practice eight)

Now, I always remember foot-therapist and eye control because I know this is my responsibility. Before the workshop, this could be a little unclear.

(GP practice seven)

The informants also experience that the formalised treatment regime helps both GPs and nurses in the sometimes difficult process of letting patients go to the nurse:

It can be difficult to let go of the patients. As a GP you have to be able to let go and trust that everything is fine when they see the nurse. Both the patients and we have to understand that they are not 'only' seeing the nurse.

(GP practice seven)

When it comes to the nurse's working conditions, the general response is that these are improved by the increased responsibility. Also, the nurses place great value in their new responsibilities because it makes their work more interesting. This is, however, on condition that the nurses have clear guidelines and instructions for their new tasks along with sparring from the GPs when needed.

3.3 Participants' perspectives on the facilitator and the workshop concept

3.3.1 The facilitator's expertise on diabetes and understanding of general practice

The interviewed GPs and staff are extraordinarily satisfied with their facilitators. All informants agreed that the facilitator's expertise on diabetes was excellent. In addition, the facilitator had a good understanding of the working conditions in general practice along with a constructive way to address areas in need of improvement as illustrated in the quotes below:

The facilitator had a very good understanding of the working conditions in general practice – she knew exactly how to spot our weak spots and was able to address them in a good way. That last part is important because GPs can have difficulties with criticism.

(GP practice seven)

When we had the second workshop and it became clear that we hadn't implemented any of the agreed changes, she was very good at stopping up and turning the workshop in the direction we needed.

(Nurse practice four)

According to the informants, the above qualities give the facilitator and the workshops a natural authority that encourages the GPs to take the concept and the results seriously.

3.3.2 The MSD workshops compared with other QI initiatives

As part of the interview, we asked the participants to compare MSD's workshops with similar/other QI initiatives that the practice had been involved with. Practice two, five, seven and eight have experiences that make such an assessment relevant. The perspectives from these practices are presented below.

The workshops focus on best practice concerning a specific diagnosis and take their point of departure in the individual practice's workflows. This is seen as a strength compared to other QI initiatives with a more broad scope:

Compared to other QI initiatives – for example 'The chronic care compass in Region Midtjylland[5]' – MSD's workshops are sweet, short and to the point. The facilitator has a professional authority on diabetes and speaks a language we as GPs understand. My practice spent four afternoons participating in the chronic care compass and it didn't bring us nearer improvements in our daily treatment. In this context, MSD's workshops were pedagogic and the point of departure was our actual workflows.

(GP practice seven)

In concurrence with the quote above, the GP from practice eight tells that:

I specifically chose MSD's workshops because I could see that the chronic care compass was too time consuming. I couldn't cope with it.

GPs from practice two also compare the workshops with the regional practice consultants[6], with the conclusion being:

MSD workshop is designed as a more professional intervention. Also compared to our usual part time consultants, it is very evident that the consultants from MSD do this as a full time job.

Finally, the informants from practice five compare MSD's workshop with a similar initiative from Boehringer, with the conclusion being that:

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[5] The chronic care compass is a large-scale regional QI initiative that aims at implementation of cross-sectorial disease management programmes for type 2 diabetes, COPD and ischaemic heart disease in general practice. The chronic care compass also aims at creating shared knowledge and a better understanding of the cross-sectorial tasks and working conditions. Further information about the project and its evaluation can be found at: http://folkesundhed.au.dk/fileadmin/www.folkesundhed.au.dk/forskningsenheden_for_almen_praksis/publikationer/udgivelser/rapporter/Kronikerkompasset_FINAL.pdf.

[6] GPs who work part time as quality consultants for the regional municipalities.

We have had a similar initiative called TOPCOLD from Boehringer. MSD's concept seemed much more professional. What made the difference was the level of formalisation. With TOPCOLD we were unsure about the process and we started with a blank paper and a lot of small notes we had to write ourselves. MSD's workshops have a much tighter structure and everything is prepared beforehand.

As illustrated above, many of the participating GPs assess that participation in the workshop is easy and the value of the outcome is perceived high compared to the time spent on participation as well as compared to other types of QI.

3.3.3 Perspectives on the workshop concept and MSD's role as an agent of change

Willingness to recommend and pay for the workshops

As part of the interview, KORA's investigator asked the informants whether they would recommend the workshop to colleagues and whether they had a willingness to pay for future workshops. In accordance with the prior results, all informants were willing to recommend the workshops to colleagues – and some GPs stated that they already did this actively in their professional networks. When it came to willingness to pay, the GPs' opinions were divided: The GPs from practice one to three had no willingness to pay and assessed that payment for the workshop concept would be unrealistic in a Danish setting. According to the informants, their willingness to close the clinic and the following lack of income during the workshop illustrated their willingness to pay. If future participants were to pay for the workshop (especially when it is taken into account that the workshops are arranged by a member of the pharmaceutical industry), the GPs assess that very few clinics would choose to participate.

Based on their experience from the workshops the GPs from practice five to eight assess that they would be willing to have paid DKK 2-3000 for the two workshops. However, the majority of the GPs also see it as a challenge to create a willingness to pay prior to the workshop. Thus, the general assessment is that it will be difficult to introduce a fee for participation in the workshops. An alternative idea brought up by informants from one practice, were to sell/adapt the concept into a regional setting where payment for the concept could be covered from the GPs' supplementary educational funds.

Creating the optimal framework for the workshops

As illustrated in the quotes below, MSD's status as a pharmaceutical company with commercial interests in general practice is very present with the informants:

One of the GPs has been a colleague with MSD's local pharmaceutical consultant. This is the only reason for our participation in the workshop. Otherwise, we never allow pharmaceutical consultants into our practice – the quality of the meetings is too low and you have to be very aware of manipulation. This being said there wasn't a shred of sale in the workshop.

(GP practice six)

Of course, I am aware that the purpose of the workshops is to create a positive image that motivates me to use MSD's products. However, with that said, I was in no way offended by the workshops. I actually didn't perceive them as representatives and that was great.

(GP practice seven)

It was good that they didn't have anything to sell. The workshop was proper!

(GP practice two)

Although, MSD's workshops appear as an exception from the informant's general dislike of pharmaceutical consultants and their visits in practice, KORA's observations and interviews suggest a dilemma concerning MSD's role as an external change agent: It can be difficult to gain access to general practice and when access is gained it can be difficult to achieve an optimal framework for the workshop. The dilemma is formulated by a GP from practice six in the quote below:

It is not realistic for the industry's consultants to take on an authoritative role because they range very low in our hierarchy.

The above dilemma points to the only real criticism raised by the informants in relation to the workshops: That some participants experienced a lack of time during the workshop. KORA's observations (which included a workshop that was cut short due to lack of time combined with delayed GPs) and feedback from the informants indicate two problems, which arise if there is inadequate time set aside for the workshop:

- A risk that the tight structured workshop concept is run through too fast – thus limiting the ownership to the results/leaving participants with a feeling that the result was determined beforehand.
- That the process is not concluded properly and/or a second workshop has to be arranged.

The evaluation does not provide a basis to conclude to what extent the above perspectives apply to the workshops in general. However, the results indicate that it may be relevant to address the question of how to ensure an optimal framework for the workshops. In this context, KORA's recommendation is that it is better to have fewer workshops with higher quality setting, than many workshops that suffer from too little time. In this connection, it should be underlined that MSD's facilitators and most of the informants[7] agree on the following points concerning the optimal framework for the workshop and the following work with changes:

- The practice should book two hours for the workshop.
- The practice – and its telephones – should be shut down during the workshop.
- To help focus and concentration the workshop should be held after or before the clinic's consultations – *not on a random Tuesday between 12 and 13.*
- It helps to succeed with intended changes, if the practice nominates responsible anchor persons and ensure follow-up meetings.

[7] As well as KORA's investigator.

In this connection, some informants suggest that MSD could incorporate a follow-up meeting and/or a short audit form the practice can use to assess their progress into the workshop concept. Some informants also suggest a more formal description of the concept and what it requires in order to maximise the chances of a good outcome.

3.4 Future adjustment and development of the workshop concept

MSD has a number of ideas for further adjustment and development of the workshop concept. The ideas and the informant's perspectives on these are presented below:

Use of quality reports from the data capture module

Regarding general drivers for implementation and adherence to the clinical guidelines, the data capture module is seen as a very important tool. The informants generally equal their implementation of the data capture module with adherence to the clinical guidelines. Also, the use of quality reports from the data capture module (for example with regard to missed appointments) is seen as a possible input to future versions of the workshop concept.

Transferring the workshop concept to other diagnoses

MSD has already applied the workshop concept to other treatment courses (lipid treatment and birth control prevention). According to the informants, it is possible to copy the workshop concept to a number of other clinical investigations and treatment of diagnoses that require systematic control and corporation across the practice team. Also, practice six has already used the workshop concept to organise their own treatment of COPD and Hypertension, while the GP from practice seven has done the same for dementia.

The diagnoses suggested by the informants range over COPD, dementia, depression, cardiac patients, pregnancy and asthma. The informants assess that it would be necessary to have a workshop on each new diagnosis, but based on their own experience they also expect the process to become easier when the process is repeated and/or when the participants have positive experience with the outcome from other workshops.

Electronic version of the workshop

So far, the workshop has been structured around a large poster and a lot of small notes that are used to map the treatment in the participating practices as seen in the picture below:

The poster is left in the practice for one to two weeks in order to give the participants an opportunity to discuss and adjust the workflow before MSD produces the finished and laminated version. After one-two weeks, an MSD consultant collects the poster and makes the laminated version that is then sent to the practice as the final product of the workshop.

This procedure requires a lot of resources and MSD is considering an electronic version with the same design and interaction between the facilitator and the participants – but with the possibility of handing over the results right after the workshop. When presented to these ideas, the informants were divided. On the one hand, approximately one third of the informants see a future electronic version as a natural step in a working environment that is increasingly electronic. On the other hand, the majority of the informants appreciate the 'old fashioned way' because they think it encourages nearness and interaction during the workshop. Several informants also find it useful to keep the poster for a while, because it enables further dialogue and adjustments of the treatment regime.

Introduction to the workshop concept as a method the GPs themselves could use

If there were one thing from this investigation that should be pointed out as being most appreciated by the participants, it would be the 'everything is served on a platter' aspect. However, the examples from practice six and seven illustrate that the GPs can conduct a version of the workshops themselves. With this 'means for self-help' perspective MSD is considering workshops/introductions to the workshop method/similar methods for QI as an offer to clinics.

When asked about this possibility a few of the informants responded positively – and suggested for example such an introduction in connection to a meeting in their local 12 GP group[8]. However, the clear majority of the informants responded negatively to the idea based on two arguments:

[8] The GP from practice seven would be willing to test the idea in his 12 GP group if his colleagues were willing to give MSD access.

- The general distrust in initiatives from the medicinal industry makes it difficult to gain access to 12 GP groups and similar professional networks.
- A generic introduction to the workshop concept/QI initiatives takes away the 'everything is served on a platter element', which is so valued by the participants. This in turn opens for the 'lack of time barrier', which is a prominent challenge for introducing external QI in general practice.

3.5 Summary of results – implementation study

In the overall perspective, the interviews indicate that MSD's workshops are highly valued by both GPs and staff. The informants associate the workshops with relevant new knowledge on best clinical practice and a shared overview of existing workflows and potential areas for improvement in the clinic's daily working routines. The laminated overview of the clinic's agreed workflows and clinical procedures in the different types of consultations is also seen as a positive and useful outcome from the workshops in all eight clinics.

The main aspects that make the workshops appealing to the informants are:

- Participation in the workshop is easy (because the workshop is formalized and has a clear goal) and the value of the outcome is perceived high compared to the time spent on participation as well as compared to other types of QI.
- MSD runs everything and the facilitators are perceived highly professional both when it comes to knowledge of diabetes and when it comes to facilitation of the workshops.

When it comes to actual changes in the workflows and division of tasks in the practice team, the investigated clinics fall in to two equally sized groups – one that has not succeeded/has not found reason for change and one that has formalised the workflows and implemented significant changes. As presented in paragraph 3.1.1 the reasons for lack of change/change is associated with lack of time and focus, no perceived need for change, disagreement among GPs and disagreement among GPs and staff.

We have also identified some denominators that distinguish the group that implements changes from the group that does not. In general, the GPs from the 'change practices' had a relatively clear (and shared in the group practice) intention of delegation and formalisation of workflows within the clinic, before participation in the workshop. The four clinics had qualified nurses with available consultation time, which could be used to relieve the GPs.

When it comes to the optimal framework for the workshop and the following work with changes, the informants agree on the following points:

- The practice should book two hours for the workshop.
- The practice – and its telephones – should be shut down during the workshop.
- To help focus and concentration the workshop should be held after or before the clinic's consultations – *not on a random Tuesday between 12 and 13.*
- It helps to succeed with intended changes, if the practice nominates responsible anchor persons and ensures follow-up meetings.

4 Survey – results

In this chapter, the results of the survey are presented, followed by a section on the time study. The chapter is concluded with a summary of the results.

4.1 Survey report

During the period November 2012-June 2013, invitations to participate in an electronic questionnaire were sent to 210 respondents (general practitioners, nurses and other clinic personnel). See section 2.2 for a detailed description of the survey design and implementation.

4.2 Survey results

The survey comprised one filter question about participation in the workshop, this was necessary because the invitation to participate was in many cases sent to the practice e-mail and could have been opened by other personnel despite being addressed to the participants by name., and 16 other questions relating to the workshop and the changes it brought about. The questions are reported below in the following categories: Overall satisfaction and perceived applicability of workshop information, knowledge gain resulting from the workshop, quantitative changes resulting from the workshop, qualitative changes resulting from the workshop, organisational changes and willingness to pay.

4.2.1 Overall satisfaction and perceived applicability of workshop information

The first question was a filter question, cf. above, and the second related to the overall applicability of the workshop to the respondents. The question was: 'The Diabetes Dialogue Workshop focused on the organisation of the treatment of diabetes patients in general practice. Was this information useful for you?' 67 respondents replied, 88 per cent said 'very much' or 'a lot'. Table 3 displays the distribution of responses:

Table 3: Applicability of workshop information

The Diabetes Dialogue Workshop focused on the organisation of the treatment of diabetes patients in general practice. Was this information useful for you?	Number	Per cent
Very much	22	33
A lot	37	55
Not so much	7	10
Don't know	1	1
Total	**67**	**100**

The respondents were also asked whether they experienced any changes in their confidence in diabetes management. The results are reported in Table 4.

Table 4: Confidence in diabetes management

Has your confidence in diabetes management changed as a result of the workshop?	Number	Per cent
Yes, I feel more confident	43	64
No, it has not changed	22	33
Don't know	2	3
Total	**67**	**100**

As seen in Table 4, almost two thirds of the respondents said that the workshop had increased their confidence in diabetes management.

Respondents were also asked if they would recommend workshop participation to other health professionals working in general practice, see Table 5.

Table 5: Recommended participation

Would you recommend the workshop to other health professionals from general practice?	Number	Per cent
Yes	48	72
Possibly	13	19
No	1	1
Don't know	5	7
Total	**67**	**100**

As seen, more than 70 per cent of the respondents would recommend others to participate.

4.2.2 Knowledge gained from the workshop

The questions relating to whether the knowledge gained from the workshop had been implemented in the clinic were divided into three: medical knowledge (Table 6), knowledge about nursing care (Table 7), and other knowledge (Table 8). The responses are presented below:

Table 6: Medical knowledge

Has the medical knowledge, you gained from the workshop, been implemented in the clinic?	Number	Per cent
Very much	15	22
A lot	39	58
Not so much	12	18
Don't know	1	1
Total	**67**	**100**

Table 7: Knowledge of nursing care

Has the knowledge of nursing care, you gained from the workshop, been implemented in the clinic?	Number	Per cent
Very much	14	21
A lot	39	58
Not so much	7	10
Not at all	2	3
Don't know	5	7
Total	**67**	**100**

Table 8: Other knowledge

Has the other knowledge, you gained from the workshop, been implemented in the clinic?	Number	Per cent
Very much	9	13
A lot	39	58
Not so much	16	24
Don't know	3	4
Total	**67**	**100**

As seen from tables 6-8 most respondents feel that the knowledge from the workshop has been implemented well. Only two people find that the nursing care knowledge has not been implemented at all during the six months after the workshop.

4.2.3 Quantitative changes

Respondents were asked to evaluate the quantitative changes that had occurred as a result of the workshop. Table 9 pertains to the length of consultations. As seen, the vast majority of the respondents find that the length of consultations has not changed.

Table 9: Length of consultations

Do you find that length of consultations has changed as a result of the workshop?	Number	Per cent
Yes, consultations have become shorter	8	12
Yes, consultations have become longer	5	7
No, the length of consultations has not changed	51	76
Don't know	3	4
Total	**67**	**100**

In Table 10, respondents were asked about the treatment capacity, in terms of number of consultations. As seen, most respondents felt that the capacity was unchanged and nobody said it had deteriorated.

Table 10: Treatment capacity

Do you find that there has been changes in the treatment capacity (i.e. how many consultations there is time for) since your participation in the workshop?	Number	Per cent
Yes, the capacity has improved	17	25
No, the capacity is unchanged	46	69
Don't know	4	6
Total	**67**	**100**

Respondents were asked whether the number of referrals to other treatments had changed for their diabetes patients since the workshop. According to Table 11, no respondents felt that the number of referrals had increased and most respondents said it had not changed.

Table 11: Number of referrals

Do you think there has been a change in the number of referrals (of diabetes patients) since your participation in the workshop?	Number	Per cent
Yes, there are more referrals now	0	0
Yes, there are fewer referrals now	10	15
No, the number of referrals hasn't changed	47	70
Don't know	10	15
Total	**67**	**100**

4.2.4 Qualitative changes

Qualitative changes in diabetes management relate to the quality of treatment (Table 12), patient satisfaction (Table 13), and patients' perception of treatment quality (Table 14).

Table 12: Quality of diabetes treatment

Do you think the quality of diabetes treatment has changed since your participation in the workshop?	Number	Per cent
Yes, the quality has improved	41	61
No, the quality has not changed	24	36
Don't know	2	3
Total	**67**	**100**

More than 60 per cent of the respondents feel that the treatment quality has improved.

Table 13: Patient satisfaction

In your experience, has patient satisfaction among diabetes patients changed since your participation in the workshop?	Number	Per cent
Yes, in my experience, patients are more content	12	18
Yes, in my experience, patients are less content	1	1
No, in my experience, patients satisfaction hasn't changed	39	58
Don't know	15	22
Total	**67**	**100**

One respondent experiences a decline in patient satisfaction and 15 respondents have no answer to this question.

Table 14: Patient perception of treatment quality

In your experience, has patients' perception of treatment quality changed since your participation in the workshop?	Number	Per cent
Yes, patients perceive quality as higher	16	24
No, patients' perception hasn't changed	32	48
Don't know	19	28
Total	**67**	**100**

More than one fourth of the respondents did not know how patients perceive the quality, and about half said there was no change. Almost one fourth of the respondents said that the patients perceived the quality as higher than before the workshop. Hence, it remains unknown if the workshop had any impact on patient's perception of quality.

4.2.5 Organisational changes

In Table 15, respondents were asked to evaluate whether the workshop had any impact on the division of labour in the clinic.

Table 15: Division of labour

In your opinion, has the knowledge gained from the workshop had any impact on the division of labour in the treatment of diabetes patients in the clinic	Number	Per cent
Yes, great impact	18	27
Yes, some impact	26	39
Limited impact	11	16
No impact	9	13
Don't know	3	4
Total	**67**	**100**

An overwhelming majority of the respondents (82 per cent) think that the workshop has had an impact (ranging from limited to great) on the division of labour in the clinic.

Table 16 relates to the variation of treatment of diabetes patients, e.g. if diabetes consultations have become more or less standardised. A smaller variation of treatment would be a beneficial outcome of the workshops.

Table 16: Variation of treatment

In your opinion, have there been any changes in the variation of diabetes treatment, e.g. have the consultations become more standardised?	Number	Per cent
Yes, the variation is smaller	19	28
Yes, the variation is greater	8	12
No, there is no change in the variation of treatment	35	52
Don't know	5	7
Total	**67**	**100**

4.2.6 Willingness-to-pay

The last question of the questionnaire was an *ex-post* willingness-to-pay question. Respondents had participated in the workshop free of charge. However, asking for their willingness-to-pay can be used for assessment of the value they assign to the knowledge they gained from the workshop. Usually, studies of willingness-to-pay are conducted ex-ante, in order for decision makers to assign a societal utility value to interventions. In this case, the responses to this question are merely for the sake of evaluation. In the design, we deviated from the ordinary design of willingness-to-pay questions by posing the question *ex-post*, and by stating that the fee would be paid for by the clinic. We considered it unlikely that people would pay from their own funds for a workshop that only benefited their workplace and not themselves. Table 17 shows the responses.

Table 17: Willingness-to-pay

In the last question please imagine, that you hadn't participated in the workshop, but were offered participation at a user charge, paid by the clinic. Considering the knowledge you now have on the workshop, would you participate?	Number	Per cent
The fee was up to 1000 DKK per participant	4	6
The fee was up to 500 DKK per participant	13	19
The fee was up to 200 DKK per participant	20	30
I would only participate if the workshop was free of charge	21	31
I wouldn't participate regardless of fee	1	1
Don't know	8	12
Total	**67**	**100**

It is striking that more than half of the respondents have a positive willingness-to-pay for a workshop. In this context it is noteworthy that the workshop has a duration of two hours per clinic. The results in Table 17 also reflect the general contentment with the workshops shown above. Also, there is only one participant who would not participate in the workshop, regardless of fee.

4.3 Time study

The aim of the time study was to investigate if there had been any changes in the treatment of type 2 diabetes patients after workshop participation compared to before. Changes could be in the division of labour, or in the amount of consultations, or both.

We expect that if there were a detectable change in the division of labour, it would be that nurses undertake more diabetes consultations and GPs undertake less, cf. the implementation study results. Developments in number of consultations could go either way.

To an extent, the results from the three clinics we have data from confirm this expectation. The results are displayed in Table 18.

Table 18: Clinic time study

	November 2011 (before workshop)	November 2012 (after workshop)	Difference 2011-2012
	Number of diabetes related contacts		
Clinic 1			
GP	3	3	0
Nurse	9	5	-4
Total	**12**	**8**	**-4**
Clinic 2			
GP	3	1	-2
Nurse	2	1	-1
Total	**5**	**2**	**-3**
Clinic 3			
GP	2	2	0
Nurse	4	12	8
Secretary	5	3	-2
Total	**11**	**17**	**6**

Note: Clinic 3 may have GP contacts in 2011 that are not registered as diabetes contacts.

Clinics 1 and 2 have seen a decline in the number of diabetes contacts, in clinic 1 only for the nurse and in clinic 2 for both health professionals. On the other hand, clinic 3, being the largest in this comparison, has experienced an increase in diabetes contacts, driven by a tripling of nurse contacts from 2011 to 2012. As noted, the number of diabetes contacts for the GP in clinic 3 may be underestimated in 2011. If this is the case, results may be more even across the three clinics.

Generally, the annual control of diabetes patients is always undertaken by the GP. Other tasks related to diabetes patients include three-month controls and blood tests. From the clinic data, it appears that the blood tests have always been undertaken by the nurse or, in one case, the secretary, whereas the three-month control appears to have been done by the GP before the workshop, and after the workshop the nurse has taken over this task. This shift in division of labour is seen in the data from clinic 2 and 3.

Interpretation of the inconclusive result of the time study should take into account that the time of the second measurement could be very close in time to the workshop participation. Thus, it is a possibility that changes are not implemented yet.

4.4 Summary of results from the survey and the time study

Almost all respondents from the survey were very content with the workshop and more than 70 per cent would recommend others to participate. A clear majority of the participants respond that the workshop has given them new and useful knowledge concerning the treatment of type 2 diabetes. The responses also indicate that this knowledge has caused positive changes concerning the division of labour and the self-assessed quality of diabetes treatment in most clinics.

Most respondents find that the workshops have had little or no impact on length of consultations, treatment capacity and number of referrals. Finally, the question concerning the participant's willingness to pay for the workshop shows a significant positive willingness to pay – which is in concordance with the overall satisfaction of the workshops. It should, however, be taken into account that willingness to pay is normally assessed ex-ante to participation. Therefore, the response to this question would probably be quite different had it been put to GPs who had not participated in the workshops.

5 Conclusion and recommendations

The overall aim of this evaluation has been to gain knowledge on the perceived outcome from participation in MSD's diabetes workshops.

The overall conclusion is that the workshops are highly valued among the participants. Most of the respondents from the survey found the workshops useful, and would recommend them to colleagues. The high value is also reflected in the responses to the question on willingness to pay, which shows that a clear majority of the participants expresses a positive willingness-to-pay for workshop participation. However, the informants from the implementation study also assess that it will be unrealistic to introduce a fee for participation prior to the workshop.

The above high degree of satisfaction was also seen among the participants who were interviewed. These informants associate the workshops with relevant new knowledge on best clinical practice and a shared overview of existing workflows and potential areas for improvement in the clinics daily working routines. Also, the laminated overview of the clinic's agreed workflows and clinical procedures in the different types of consultations is seen as a positive and useful outcome from the workshops in all eight clinics. Finally, the participants see a potential to transfer the workshop concept to other treatment regimes that require systematic control and corporation across the practice team.

Both the survey and the interviews indicate that most participants have implemented the knowledge gained, and have made changes in the organisation of diabetes treatment. The interviews show minor changes concerning the use of laboratory tests and updated knowledge on current clinical guidelines as an outcome in seven of the eight participating practices. Finally – but not least – participants from four of the eight clinics state that the workshop has helped them to achieve significant changes that delegate tasks from GPs to nurses. In accordance with KORA's previous studies of the area (12, 13) the informants associate the achieved changes with better quality and freed resources for the GPs.

The time study does not reflect a clear picture of changes in division of labour, however. This may be due to the very small number of clinics providing data for the time study.

Generally, we cannot conclude on the external validity of our findings. The possible selection bias into workshop participation prevents us from concluding in more general terms about QI in general practice. It cannot be ruled out, that workshop participants are more motivated for QI and organisational change than non-participants. Also the survey response rate – about one third – prevents us from generalising the answers to all participants. We have, however, no reason to believe that the people who responded are more or less content than the people who did not. The same applies for the interview participants, who were randomly selected among workshop participants.

The survey was conducted six months after the workshop, and hence there is a risk of recall bias. The survey does however only relate to changes occurring after the workshop and hence the six months is considered an acceptable time span.

Recommendations

In the light of the evaluation's positive findings, our main recommendation is to maintain the workshop concept and the experienced facilitators. Also it seems important to keep

attention on ensuring an optimal framework for the workshop as summarized in paragraph 3.5.

Although the investigation indicates a backward pointing willingness to pay for the workshop concept, it is the impression from the interviews that it is not realistic to introduce a financial charge on the workshops.

An alternative way to spread the use of the workshop concept could be to contact regional organisations and key actors responsible for QI in general practice. Such meetings could investigate the possibility to corporate on development and dissemination of the workshop concept.

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Appendixes

Appendix 1: Interview guide

Introduction: Name, education, position, number of years in the clinic

1. Your own version of the outcome from participation in MSDs workshop

i. Internally in the clinic?

ii. Outcome for the patients?

a. Why did you agree to participate?

b. Would you recommend other clinics to participate?

i. Why/why not?

ii. Can all clinics benefit from the workshop?

iii. Is there something participants should be aware of/prepare before the workshop?

iv. Comparison with other QI initiatives targeted at general practice?

2. Actual changes in the daily working routines

a. Workflows and division of tasks between GPs and staff?

b. Time spent on diabetes treatment?

c. Capacity and ability to treat diabetes according to existing guidelines?

d. Quality of treatment?

e. Other results – e.g. changes in laboratory tests or proactive monitoring/and call of patients who forget controls?

3. Implementation of change

a. Who did what in order to achieve the changes that were agreed upon at/following the workshop?

b. To what degree have you reached your intended goals?

c. What drives and barriers have there been for the implementation?

4. 1. vs. 2. workshop – if relevant

a. Why agree to a second workshop?

b. Were the workshops coherent?

c. What was the outcome of the second workshop?

5. **Perspectives on MSD's workshops and implementation of change**
    a. Have you needed external support to realise the ideal treatment regime that was described at the workshop?
        i. If yes – what could this support have looked like?
        ii. Was there anything MSD could have helped with – e.g. hotline or follow-up meetings with focus on progress?

6. **Practice size – small vs. group practice – has it meant anything for:**
    a. The workshop?
    b. Implementation of changes?
        i. The need for implicit vs. explicit workflows etc.?

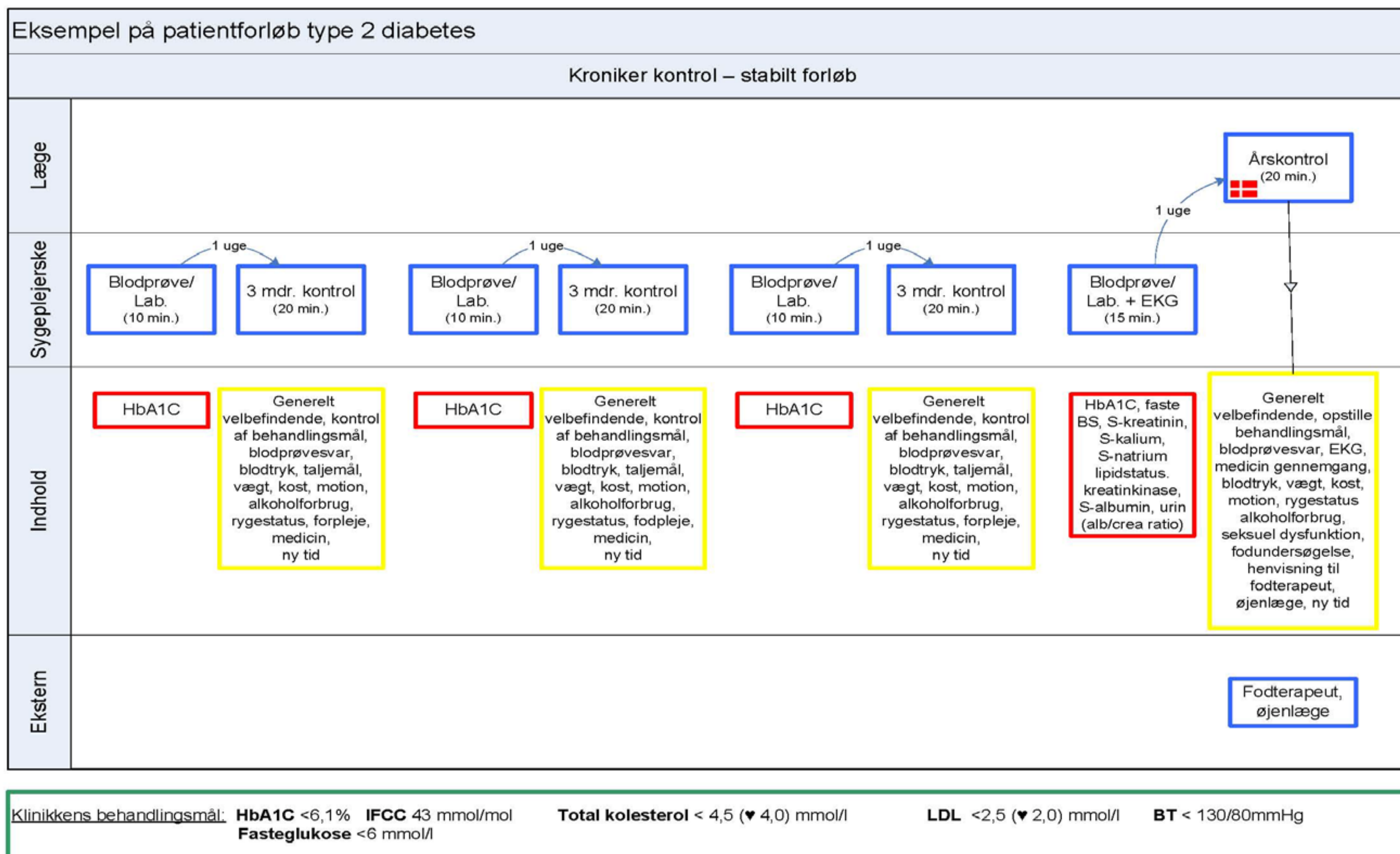
7. **Perspectives on the workshop**
    a. The role of the facilitator?
    b. The professional level of knowledge of diabetes?
    c. Knowledge and understanding for general practice?
    d. Perspectives/suggestions for improvements related to the workshops form and structure?

8. **Suggestions for further development and new initiations concerning QI in general practice?**
    a. Interest in workshops/networks related to learning about methods for QI – e.g. in the local 12 GP training groups?
    b. Other relevant forums for QI?
    c. Challenges for further QI initiatives – e.g. lack of time, overlap with existing networks/initiatives?

9. **Data driven development?**
    a. What's your current status with the data catch module and what perspectives for improvement do you see in the module?
    b. Could it be fruitful to use reports from the data catch module as impetus for workshops?
    c. Advantages/disadvantages if the mapping of workflows at the workshop and the laminated description of the clinics treatment regime was made electronic?

10. **Anything to add/something we should have asked about?**

Appendix 2: Treatment regime that is handed over to the clinic after workshop



Appendix 3: Survey letter and content

Kære <deltager>,

For ca. et halvt års tid siden deltog du og dine kolleger i MSD's Dialog Diabetes workshop. MSD har bedt KORA (tidl. DSI) om at evaluere dialogworkshoppen, og det vil vi gerne bede dig deltage i.

Formålet med evalueringen er at finde frem til, om en ændring af arbejdsgange er til gavn for diabetespatienterne i almen praksis. For at kunne analysere det, har vi brug for din mening.

Vi vil bede dig om at klikke på linket herunder og besvare de 17 spørgsmål. Det tager højest 5 minutter. Det er meget vigtigt at det er dig personligt der besvarer spørgsmålene. De af dine kolleger, der også deltog i workshoppen, har fået et tilsvarende spørgeskema. Det er jeres personlige holdninger, uanset om de er positive eller negative, vi er interesserede i.

Link til spørgeskema <link>.

Vi vil godt bede dig om dit svar inden den <dato>.

Som tak for din hjælp sender vi dig et par flasker vin eller en boggave efter eget valg.

Denne undersøgelse er godkendt af Datatilsynet (j.nr. 2012-54-0158) og Multipraksisudvalget for almen praksis (sag MPU 15-2012). Besvarelserne opbevares sikkert, og respondenterne vil ikke kunne identificeres, hverken af MSD eller KORA.

Mange tak for din hjælp

Venlig hilsen

Marie Kruse

Senior projektleder, cand.polit., ph.d.
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KORA – **Det Nationale Institut for Kommuners og Regioners Analyse og Forskning –** er en fusion mellem **Dansk Sundhedsinstitut**, AKF og KREVI.

Spørgeskema til ansatte i almen praksis

1. Deltog du i Dialog Diabetes workshoppen, afholdt af MSD for ca. et halvt år siden?

   ☐ Ja
   ☐ Nej
   ☐ Kan ikke huske

2. Dialog Diabetes workshoppen handlede især om, hvordan behandlingen af patienter med type 2 diabetes kan organiseres i almen praksis. Var den information **anvendelig** for dig?

   ☐ I meget høj grad
   ☐ I høj grad
   ☐ I mindre grad
   ☐ Slet ikke
   ☐ Ved ikke

3. Er den **lægefaglige** viden, du fik på Dialog Diabetes workshoppen, efter din mening blevet implementeret i klinikken?

   ☐ I meget høj grad
   ☐ I høj grad
   ☐ I mindre grad
   ☐ Slet ikke
   ☐ Ved ikke

4. Er den **sygeplejefaglige** viden, du fik på Dialog Diabetes workshoppen, efter din mening blevet implementeret i klinikken?

   ☐ I meget høj grad
   ☐ I høj grad
   ☐ I mindre grad
   ☐ Slet ikke
   ☐ Ved ikke

5. Er den **øvrige** viden, du fik på Dialog Diabetes workshoppen, efter din mening blevet implementeret i klinikken?

   ☐ I meget høj grad
   ☐ I høj grad
   ☐ I mindre grad
   ☐ Slet ikke
   ☐ Ved ikke

6. Synes du, at der er sket ændringer i **konsultationslængden** i konsultationer med type 2 diabetes patienter efter jeres deltagelse i Dialog Diabetes workshoppen?

   ☐ Ja, konsultationerne er blevet længere
   ☐ Nej, konsultationslængden er uændret
   ☐ Ja, konsultationerne er blevet kortere
   ☐ Ved ikke

7. Synes du, at der er sket ændringer i **behandlingskvaliteten** i forhold til type 2 diabetes patienter efter jeres deltagelse i Dialog Diabetes workshoppen?

☐ Ja, kvaliteten er blevet bedre
☐ Nej, kvaliteten er uændret
☐ Ja, kvaliteten er blevet dårligere
☐ Ved ikke

8. Mener du, at de ting, du lærte på Dialog Diabetes workshoppen, har haft **betydning for arbejdsfordelingen** i forhold til type 2 diabetes patienter i klinikken?

☐ Ja, stor betydning
☐ Ja, nogen betydning
☐ Begrænset betydning
☐ Ingen betydning
☐ Ved ikke

9. Synes du, at der er sket ændringer i **behandlingskapaciteten (hvor mange konsultationer der er tid til)** i forhold til type 2 diabetes patienter efter jeres deltagelse i Dialog Diabetes workshoppen?

☐ Ja, den er forbedret
☐ Nej, behandlingskapaciteten er uændret
☐ Ja, behandlingskapaciteten er forværret
☐ Ved ikke

10. Synes du, at der er sket ændringer i **antallet af konsultationer** med type 2 diabetes patienter efter jeres deltagelse i Dialog Diabetes workshoppen?

☐ Ja, der er flere
☐ Nej, det er samme antal
☐ Ja, der er færre
☐ Ved ikke

11. Synes du, at der er sket ændringer i **variationen af behandlingen** i forhold til type 2 diabetes patienter efter jeres deltagelse i Dialog Diabetes workshoppen (oplever du fx konsultationerne som mere standardiserede)?

☐ Ja, der er større variation
☐ Nej, variationen er uændret
☐ Ja, der er mindre variation
☐ Ved ikke

12. Oplever du, at der er sket ændringer i **den patientoplevede kvalitet** for type 2 diabetes patienter efter jeres deltagelse i Dialog Diabetes workshoppen?

☐ Ja, patienterne oplever kvaliteten som højere
☐ Nej, den patientoplevede kvalitet er uændret
☐ Ja, patienterne oplever kvaliteten som lavere
☐ Ved ikke

13. Oplever du, at **patienttilfredsheden** blandt type 2 diabetes patienter har ændret sig efter jeres deltagelse i Dialog Diabetes workshoppen?

☐ Ja, jeg oplever at patienterne er mere tilfredse
☐ Nej, jeg oplever at patienterne er ligeså tilfredse som tidligere
☐ Ja, jeg oplever at patienterne er mindre tilfredse
☐ Ved ikke

14. Synes du, at der er sket ændringer i **antallet af viderehenvisninger** af type 2 diabetes patienter efter jeres deltagelse i Dialog Diabetes workshoppen?

☐ Ja, der er flere viderehenvisninger
☐ Nej, antallet af henvisninger er uændret
☐ Ja, der er færre viderehenvisninger
☐ Ved ikke

15. Er din oplevelse af at **føle dig rustet** i behandlingen af type 2 diabetes patienter ændret efter jeres deltagelse i Dialog Diabetes workshoppen?

☐ Ja, jeg føler mig bedre rustet
☐ Nej, det er uændret
☐ Ja, jeg føler mig dårligere rustet
☐ Ved ikke

16. Ville du anbefale Dialog Diabetes workshoppen til andre ansatte i almen praksis?

☐ Ja, jeg vil anbefale andre at deltage
☐ Jeg vil muligvis anbefale andre at deltage
☐ Nej, jeg vil ikke anbefale andre at deltage
☐ Ved ikke

17. Som det sidste spørgsmål vil vi bede dig **forestille dig**, at du ikke havde deltaget i workshoppen, men nu fik tilbuddet om at deltage, denne gang for en **brugerbetaling**, afholdt af klinikken. Med den viden, du i dag har om workshoppen, **ville du så have deltaget, hvis**:

☐ Det kostede klinikken 1.000 kr. pr. deltager
☐ Det kostede klinikken højst 500 kr. pr. deltager
☐ Det kostede klinikken højst 200 kr. pr. deltager
☐ Jeg ville kun deltage, hvis det var gratis
☐ Jeg ville ikke deltage uanset hvad
☐ Ved ikke

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