Barriers & Facilitators of Optimal Diabetes Management in General Practice; a Qualitative Study

Dr Sheena Mc Hugh- Department of Epidemiology & Public Health, UCC
Dr Monica O’Mullane- Department of General Practice, UCC
Prof. Colin Bradley- Department of General Practice, UCC
Prof. Ivan Perry- Department of Epidemiology & Public Health, UCC
Background

1982...
• The “care of diabetics requires enthusiasm and organisation”
  ▫ Management of uncomplicated diabetes takes place in general practice by trained staff working closely with hospital specialists
  ▫ Regular review, use of special records for diabetes care & nurse involvement

2012....
▫ Uncomplicated cases of Type 2 diabetes seen in primary care
▫ Type 1 diabetes and complex cases of Type 2 diabetes will continue to be seen in secondary care
▫ Register, review & recall= components of a comprehensive diabetes service

• Survey of diabetes care in Ireland
  ▫ Inconsistent use patient registers, regular review etc
    • 24% did not use a register, guidelines or call/recall system for patients with diabetes
  ▫ Deficient access to services
    • >30% did not have access to a dietician
    • >40% did not have access to foot-care
  ▫ Lack of formal integration between settings
    • 3% of GPs had regular meetings with hospital team
    • 90% did not have a shared protocol with secondary care

Aims

1. To elaborate on experiences of delivering diabetes care in general practice.

2. To explore perceptions of the barriers and facilitators to providing diabetes care in everyday general practice.
METHODS
Opt-in through preceding survey

N = 213 (81%)
25/26 counties

3 sets of criteria:
Urban/Rural
Single/group practice
Computerised/not

31 Interviews
29 GPs & 2 Practice Nurses
## Participants (N=31)

<table>
<thead>
<tr>
<th>Category</th>
<th>Urban (16)</th>
<th>Rural (15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single (15)</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Computerized Non-computerized</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Group (16)</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Computerized Non-computerized</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
TOPIC GUIDE:

✓ Current provision of diabetes care

✓ Factors influencing the optimal delivery of diabetes care

✓ Wish list for diabetes care in Ireland

✓ How have things changed locally and nationally

✓ Attitudes to a national diabetes register and engaging in audit in the practice.
Data Collection & Analysis

- July-January 2010
- Interviews recorded & transcribed (25mins-1.5 hrs)
- Analysis=Framework Approach (Richie & Lewis, 2006)
- Ethical approval obtained from the ICGP
Key Findings
Barriers & Facilitators

1. Occur at multiple levels of the health system (patient, professional, practice, system, culture)

2. Have knock-on effects at different levels of the system
Lack of Remuneration

“I mean if we’re getting no recognition and no incentive and no remuneration or anything to do this work, I’d be mad in the head to keep doing it unless I charge the patient and I don’t like doing that but I don’t have any choice”

“You feel there is a sense of why get someone else to do it when the GP will do it for free”

“At the moment care is opportunistic but if there were incentives for me to hold a clinic that would help. We could keep flow charts and I’d get remuneration. This takes a lot of time, manpower, secretarial time, nurse time, and at the moment there’s no incentive to do that.”

“I would love to see the care of all chronic illnesses recognized as a core part of our health system and general practice is really the only place that it can be done efficiently or economically but our present contract doesn’t reflect”
<table>
<thead>
<tr>
<th>Vocational Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal satisfaction</strong></td>
</tr>
<tr>
<td><strong>Personal experience</strong></td>
</tr>
<tr>
<td><strong>Job satisfaction</strong></td>
</tr>
<tr>
<td><strong>Seeing improvement</strong></td>
</tr>
<tr>
<td><strong>Patient Feedback</strong></td>
</tr>
<tr>
<td><strong>Professional Duty</strong></td>
</tr>
</tbody>
</table>
“Pockets of Interest”

- Vocational/personal incentives motivating a subgroup of practices to plan and provide structured care to patients.

- Beyond this group, remuneration and financial incentives are the main facilitator to providing high quality care.

“That [remuneration] is going to hold back the roll out of this sort of work around the country” (UGC)
Barriers & Facilitators at Primary-Secondary Interface

- Hospital = “an essential resource” and a “doorway to services”

- Lack of coordination between settings
  - Hospitals “overburdened”
  - Waiting Times
  - Poor communication creating tension
“In the Meantime” Care

- Used to define the unknown period of GP management between reviews

“I notice that they’re pushing them [reviews] out further and further, the review would’ve been 6 months maybe some time ago. Its gone to yearly, its gone to two-yearly. So that means I suppose that we’re to pick up in the meantime. But yet there’s been no ... communication, there’s been no meetings, there’s been no working group, there’s no, its just sort of left like that.” (USC)
“If you could say to them [patients] ‘look this is your diagnosis, this is what we’re going to discuss and over the next 2 weeks you’re going to meet A, B and C, and then we have a baseline for everything covered from day 1 and you know exactly where you are, you’re on a springboard ready to jump. As opposed to saying ‘stand on the springboard for about 2 months and then we’ll jump you into that and then 2 months later you might get called for your eyes and 2 months later you might get called for your feet’ in which time they’ve had a problem with their feet and they’re not quite sure how they should have dealt with it” (Nurse, RGC)
The Current “Palaver”

- Lack of clear boundaries and bureaucracy wasting time & resources

“at the moment its a big palaver if you get cholesterol checked, get it to the patient to bring to the hospital, it gets lost in the process lots of times...And it just seems incredibly wasteful of effort and time and resources” (UGC)

“They spend the last precious days of their lives going around from outpatient to out-patients, confused as to who to believe, and in the ideal world the GP service would be coordinating and making sure it doesn’t happen to much.” (RGC)
Avoidable Duplication

• Powerless against duplication as practices needs access to services
  
  “Unfortunately they still have to be seen in the hospital annually for things like retinopathy screening and podiatry...they have to go through the clinic. There’s a bit of duplication that goes on there that could be avoided”

  “One of our problems is to make sure they don’t have 2 annual eye tests in different places...have all their bloods done a fortnight apart...Simple sort of communication things but they are still difficult”
Mechanisms for Improving Integration

- Shared Information Systems

- Shared Protocol
  - Clarity around the remit of GPs and the hospital team.

“It would be nice if it was more formal, some kind of protocol drawn up as to who we should send and who we shouldn’t send” (RGC)

“...where an integrated guidelines are drawn up, where everybody knows what is going on, what’s happening, whose responsibility is what and then you would know the resources are best used” (USC)
Facilitator: Greater Sharing, not ‘either/or’ care

- Combine the strengths of both settings

“If you only deliver care in acute settings then people are left floundering for 6 or 9 months in between but equally if you only see them in the community and they don’t have a link of some description with the hospital when they run into a problem it’s sometimes very difficult to get somebody in quickly because they’re not part of the system” (Nurse, RGC)
Attitudinal Challenges

- Questioning the need for integrated care

“They say about patients going into the hospital and all that but then what else would they be doing really”....

“I wouldn’t like to see general practice becoming a second best system, i.e. shared care of diabetes, chronic disease etc. I don’t mind doing some of this work but want to remain as ‘primary care doctor’...

[What do you understand by sharing care with the hospital?] A system whereby the GP sees the patients for bloods and whatever, the initial diagnosis and that, but then the hospital would be saying do this and do that. I mean you have to be careful with diabetes because you have to prevent the serious complications and they need to have all the eyes and feet and all the finer things done in the hospital.

(GP, Urban, Single-handed, non-computerised)
Support Services: Diet, Feet & Eyes
“Not enough of them and too hard to access”

- Community Services = “Abysmal”, “non-existent”
  - Relying on hospital

  “I think that’s the barrier to the service as a community-based thing running properly, because you have to access the acute services to get somebody in.”

- “Patchy access”: on a scale

  “Some things are good and some are bad. Foot care is not particularly good, it’s a bit random. Dieticians were good, we had a community dietician and then she went on maternity leave and wasn’t replaced so now again it’s a bit patchy”

- Patients and families “muddling through”
Facilitator = Luck

We're very lucky here, in that we've had a very good access to a dietician for the last few years now. (RGC)

“If they needed to see a podiatrist we have one almost next door. We make sure that their eyes have been checked within the last 12 months, and we have an arrangement with an ophthalmologist not too far away. We’ve a nice loop or link with the other professions that are needed – the feet, the eyes, the diet.... so they are rather lucky patients.” (UGC)
“People like diabetic nurses are worth their weight in gold”

- Nurse = facilitated coordination & deliver of structured systematic care
- Team approach:
  
  “a combination of themselves and ourselves”

- Nurse-led management

  “They’re invited to what [the nurse] calls a ‘diabetic clinic’. She has a routine she works through; bloods and all that kind of thing, goes over diet and exercise, checks their feet. So she has done it fairly independently”
Summary

• System-level deficiencies impacting on practices, professionals and patients

• Overlap with the ‘inadequacies’ highlighted in the primary care strategy (2001)
  ▫ Poor primary care infrastructure
  ▫ Fragmented services
  ▫ Lack of availability of certain professional groups
  ▫ Poor liaison between settings
  ▫ Failure to realise the potential of primary care to ease the pressure on secondary care.

• Similar challenges in the UK:
  ▫ Ranking: Access to dieticians and podiatry a bigger barrier than access to ophthalmology
Important to anticipate differing positions on the need and capacity for integrated care:
- Need for flexibility in a national model of care to allow for varying levels of capacity to manage diabetes in the practice.

Focus was on organisation and structural barriers and facilitators in General Practice
- Patient-related factors
- Other professionals in other settings
Acknowledgements

- GPs and Practice Nurses who participated in the study
- ICGP
- HRB PhD Scholars Programme in Health Services Research

- s.mchugh@ucc.ie