Integrated Diabetes Care
vs
Cycle of Care

Midland Structured Care Diabetes Perspective

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Optimal Diabetes Management

Optimal diabetes management requires an organised, systematic approach and the involvement of a co-ordi-nated team of dedicated health care professionals working in an environment where patient-centred high-quality care is a priority .

ADA Guidelines 2015

Why General Practice?

- Geographical access
- Structures already in place
- Equity of treatment and access
- Person-centred, not disease-centred care
- Complex co-morbidity

Adapting International Guidelines to Irish Practice - timeline of MSDCP

1997	Piloted in one practice. Dr V Harkins, GP & Dr D de la Harpe, Public Health
1998	10 GPs in 9 practices recruited
2001	Further 10 GPs in 7 Practices recruited.
1998-2003	20% Increase in diabetic population
2005	14 additional practices recruited.
At Present	31 practices (23 in Heartwatch) 80 GPs in scheme & 4000 patients active

Evolvement of Programme

Link with the former Midland Health Board formalised

This facilitated funding for Chiropody & Dietetic Support delivered in the Practices

Diabetes registers developed at practice level (manual & computerised)

Direct referral to community ophthalmology service agreed

Structured approach to diabetes management adopted in 10 practices

Research Support from Dept of Public Health – Audits 2003 and 2009, re-audit currently underway Oct 15 with UCC

Clinical Support Provided

Diabetes register in all practices

Guidelines For Integrated Care Of Type 2 Diabetes In General Practice developed in 2008, revised 2012

Dietetics & chiropody provided in practice

4 Primary care diabetes nurse specialists appointed

Diabetes care pathway developed

Foot care assessment tool developed

Insulin initiation programme developed & implemented

Ongoing staff training

Educational Support

Development of:

- patient diabetes education guidelines
- education manual for Practice Nurses "*What You Need to Know about Diabetes*"
- foot assessment & risk classification protocol, with provision of videos on foot assessment

Provision of interdisciplinary Educational Seminars across care settings covering topics such as:

Linking Hospital & Community

Initiation of insulin therapy in General Practice

Treatment of hypertension in patients with diabetes

Research Support

Research carried out under direction of Diabetes Structured Care Research Group.

Group meets once or twice a year and consists of

- GP leader
- specialist in public health
- project managers from primary care
- researcher
- CNS for diabetes / primary care

Role of the GP

The GP carries overall responsibility and leadership in the running of integrated diabetes care in the community.

Responsibilities are to ensure:

Practice staff members are familiarised with agreed models of care, including algorithms, patient information, guidelines etc.

All members of team are aware of their roles and responsibilities

Patients are treated in line with National Diabetes Programme Protocols

Appropriate governance in place in order to ensure continuing improvements in quality, safety, access and cost effectiveness

Up to date register of patients with type 2 diabetes maintained with regular register management

Adaptation to new guidelines as they are developed

Role of the Practice Nurse

Provide regular diabetes routine care in the practice as per visits set out in agreed model

Maintain practice diabetes register

Set targets with patients

Provide patient education re diet / lifestyle / exercise etc

Carry out initial and annual foot assessment as per national model

Refer patients to community DNS and for retinal screening, dietetics & podiatry as per national model

Refer agreed patients to secondary or tertiary care as per agreed model

Return patient data as required

Role of the Community D.N.S.

These nurses are highly skilled and have specialist post -graduate training in diabetes care

See individual patients referred to him / her by the GP / PN

Provide training and support to Practice Nurses within the GP practice to set up and deliver integrated diabetes care package

Deliver education programmes, in conjunction with the local nursing education units, for example the HETAC Certificate in Diabetes, along with annual multidisciplinary master classes

Liaise with secondary care and actively participate in team discussions regarding best quality care is provided for all diabetes patients

Carry out research and audit, including using audit data to influence the delivery of the integrated diabetes care package at practice level

Practice Management Structure

Initial Assessment By GP/PN

Record B/P, BMI, Waist Circumference
Record baseline blood investigations
Review family & medical history

Assess lifestyle issues

Set individualised targets for glucose control, BP, lipids, anti-platelets, lifestyle, renal disease, foot & eye care and vaccinations

Screen for complications

Refer for dietetic, chiropody, ophthalmic consult

Educate **PN offers baseline diabetes self management education**

- Review aims of diabetes care
- Home BGM & calibration, if appropriate*
- Medication management
- Psychological support

**The guidelines for self-monitoring of blood glucose are currently under review*

4 Monthly Review

Practice Nurse & G.P Role

Investigations Hba1c, Lipids (if raised at last visit), ACR, Serum Creatinine, Iron, Transferrin (if ferritin previously raised), Annual ECG, Weight, BP

Assess feet according to National Footcare Model, injection sites

Assess smoking status & physical activity level

Follow up on dietetic, podiatry, ophthalmic consults and annual review

Practice nurse educates on self management issues

Hypo/Hyperglycaemia

Entitlements LTI/DFI

Employment /Driving /Travel advice

Pre-conceptual advice

Foot Assessment

On diagnosis of diabetes and at annual review thereafter trained practice nurse will examine patient's feet and lower limbs for risk factors, this should include:

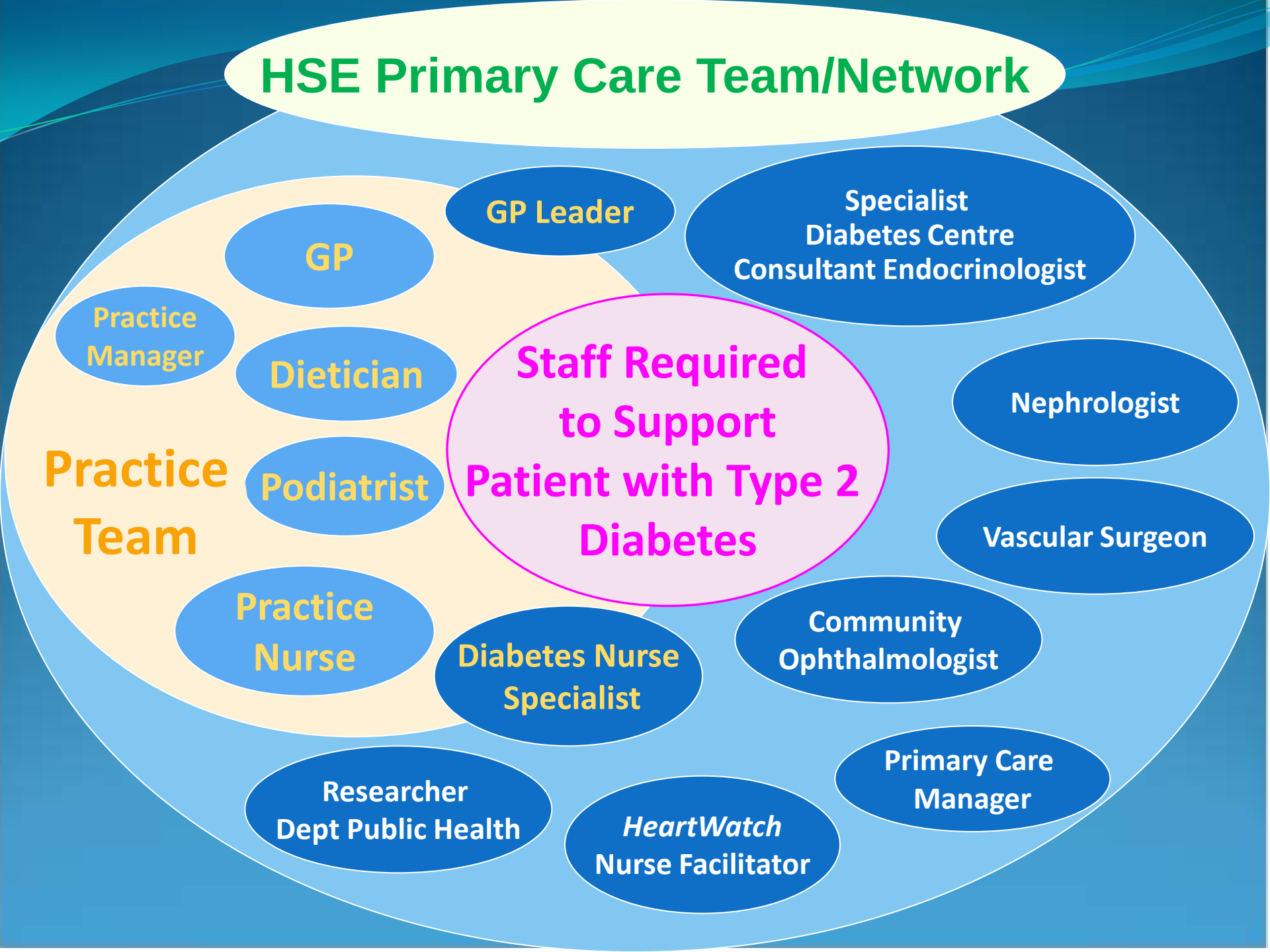
Testing vibration and 10g monofilament sensation

Palpation of dorsalis pedis & posterior tibial pulses in both feet

Inspection of any foot deformity

Inspection of footwear

Feet will be classified into three categories:


HSE Primary Care Team/Network
GP Leader
Specialist
Diabetes Centre
Consultant Endocrinologist
GP
Practice
Manager
Dietician
Staff Required
to Support
Patient with Type 2
Diabetes
Nephrologist
Practice
Team
Podiatrist
Vascular Surgeon
Practice
Nurse
Community
Ophthalmologist
Diabetes Nurse
Specialist
Primary Care
Manager
Researcher
Dept Public Health
HeartWatch
Nurse Facilitator

Audit Results

BLOOD PRESSURE	Systolic	Diastolic
Midlands 2010 (n=1000)	48% (less than 130mmHg)	73% (less than 80 mmHg)
UK Diabetes Audit 2012-13	69% less than 140/80mmHg	
STOP-HF Midlands (n=152)	128mmHg mean (sd 18)	71mmHg (sd 11)

CHOLESTEROL	TOTAL < 5 mmol/L	HDL mmol/L	LDL mmol/L
Midlands 2010 (n=1000)	81%	1.2	2.1
UK Diabetes Audit 2012-13	77.6%		
Scottish Diabetes Audit 2013	79.5%		
STOP-HF Midlands (n=152)	3.8 mean (sd 0.9)	1.4 mean (sd 1.3)	2.2 mean (sd 1.0)

HbA1c	Less than 58mmol/L (7.5%)
Midlands 2010 (n=1000)	71%
UK Diabetes Audit 2013	62.2%
Scottish Diabetes Audit 2013	63.3%
STOP-HF Midlands (n=152)	48.7mmol/L mean (sd 13.6)

Midland DSCP Research Projects

STOP-HF Programme 2014 (BNP) – Prof Ken McDonald

Counting on commitment; the quality of primary care-led diabetes management in a system with minimal incentives 2011 – Dr Sheena McHugh

Management of diabetes in primary care: a structured-care approach 2008 – Prof Ivan Perry

Diabetes Quality of Life Study 2003 – Prof Ivan Perry

What is the Cycle of Care?

Commenced in September 2015, it is a GP based diabetes management programme.

Only available to the estimated 70,000 GMS and Doctor Visit Card holders with T2 Diabetes; 91,500 private patients are excluded.

Provides for two diabetes review consultations per year.

At end of year, diabetes data uploaded by GPs to PCRS site. Dataset still to be confirmed.

Cycle of Care Visits - First

Review

- Blood Test Results: HbA1c, Lipids, Creatinine & ACR,
- Preventative lifestyle factors: smoking, alcohol, exercise, weight control and provide brief intervention and referral if appropriate
- Medication
- Foot status and referral if appropriate
- Participation in eye prevention programme & referral if appropriate

Record

- BP and manage as appropriate
- BMI and manage as appropriate
- Immunisation status (flu and pneumococcal)

Provide

- Diabetes patient education and refer to Patient Education Service if newly diagnosed

Recall

- Schedule next review

Cycle of Care Visits - Second

Review and Record

- HbA1c and Lipids
- Preventative lifestyle factors: smoking, alcohol, exercise and weight control
- BMI and refer on if appropriate
- Blood pressure

Carry out review of medication.

Data to be submitted annually to PCRS on registered patients

Challenges Ahead

While welcoming announcement of new Diabetes Cycle of Care, firmly placing diabetes care in general practice setting, there are challenges ahead:

- **Leading research supports 3 visits per year, to achieve best practice an additional visit is required.**
- **Lack of co-ordination with National Diabetes Programme and no reference to the already agreed Model for Integrated Care.**
- **Clarification required of care pathways for Type 1 /Complicated /Uncomplicated patients.**
- **Limited to GMS patients only; 57% patients with T2DM excluded, programme needs to be extended to cover all.**
- **Patient referral pathways for CNS diabetes / podiatry / dietetics to be confirmed.**

Challenges Ahead

IN THE PRACTICE:

Organisation: 3 Rs Register – Review – Recall

Protected PN time Education for GPs & PNs Audit time

FOR THE ICGP

Taking a lead role clinically - Diabetes Task Group set up involving GPs from Diabetes Interest Groups across the country, Diabetes Roadshows arranged for GP & PN education to support Cycle of Care .

Need urgent issue of National Diabetes Guidelines & Model of Care

NATIONALLY

Patient consent issues, HSE consenting after registration of patients.

Data storage and access, integration with current GP software.

Appointment of additional CNSs where GPs sign up.

Co-ordination & roll out of patient structured education programme

Formal re-engagement between ICGP & National Clinical Care Programme

ICGP Diabetes Roadshow Dates

Limerick	9th January 2016
Dublin	30th January 2016
Cork	6th February 2016
Galway	27th February 2016
Waterford	5th March 2016
Sligo	9th April 2016

Topics to be covered: Organisation of Care, Update on Therapeutics and Setting Targets, Roles within the Diabetes Team, Practical Workshops on glucometers, foot care, patient education.

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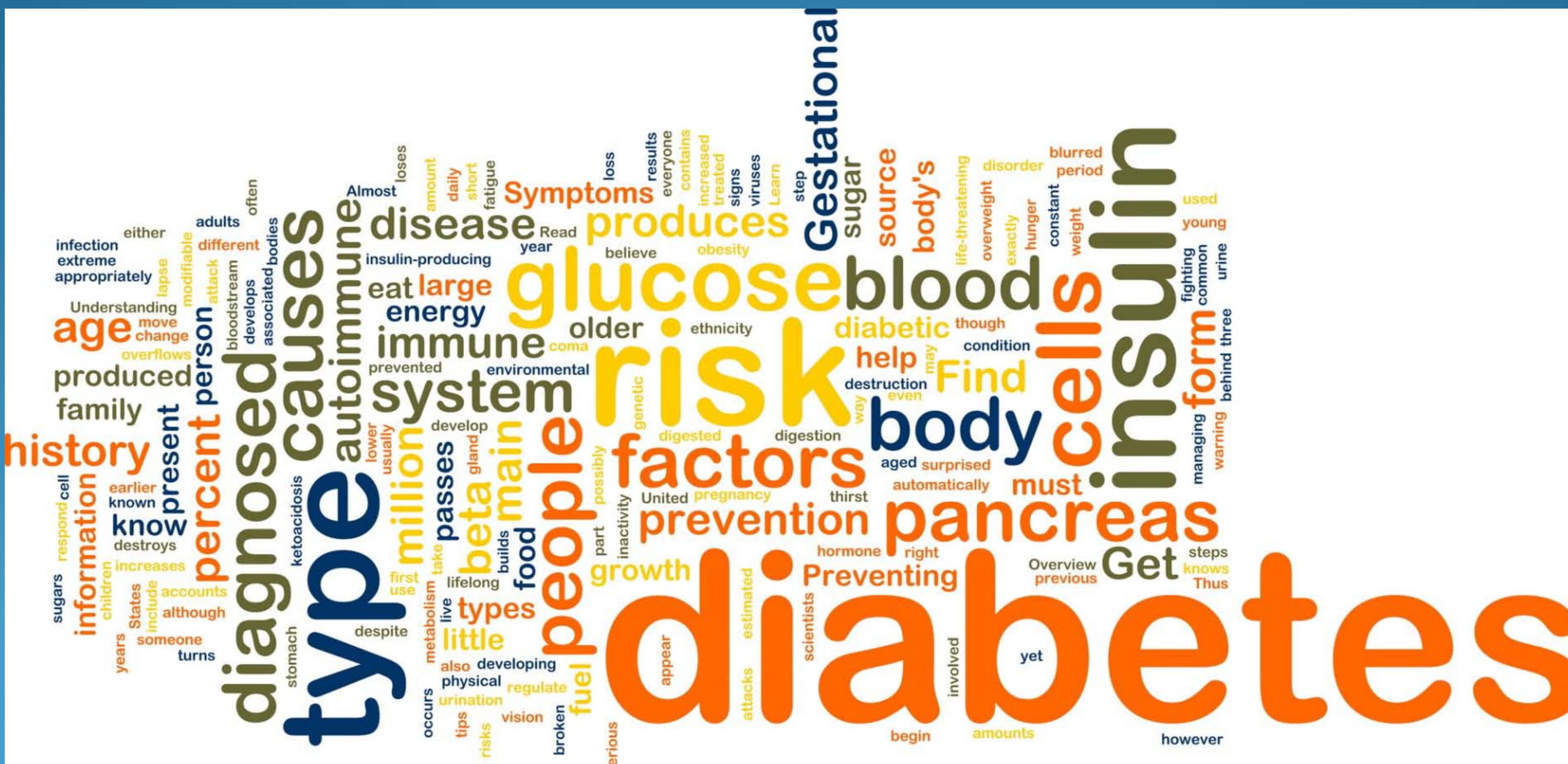

diabetes
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people
prevention
Preventing
Gestational
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immune
autoimmune
disease
Symptoms
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history
age
produced
family
percent
person
present
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