Structured Care of Diabetes in General Practice: A Qualitative Study of the Barriers and Facilitators

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Abstract

This qualitative study explored general practitioners and practice nurses perceptions of barriers and facilitators to the proposed transfer of diabetes care to general practice. Qualitative data were collected through five focus groups which included GPs (n=55) and practice nurses (n=11) representing urban (44%), rural (29%) and mixed (27%) practices, in the Irish Mid-West region. Barriers and facilitators were mentioned 631 times (100%). Barriers were mentioned 461 times (73%), facilitators 170 times (27%). The most frequently identified barriers were lack of access to secondary resources (15%), lack of access to secondary care (19%), lack of a systematic way to recall or track patients with diabetes through computer systems “bringing up the computer register and being able to generate the recalls. Without that it is not going to work”.

In Ireland, it is estimated that 5% of the population have diabetes of these 1% have type 2 diabetes. Globally there is mounting evidence that a primary care-led health system can provide improved health outcomes at sustainable costs compared to a system centred on hospital care and specialists. Provision of structured diabetes care in general practice, has been shown to provide equivalent standards of care to that achieved by hospitals, with an enhanced diabetes quality of life. In reviewing barriers experienced by GPs to the management of type 2 diabetes patients, four domains emerged, namely patient, practitioner, practice and system factors. A structured diabetes care programme does not currently exist in Ireland. The Irish Health Service Executive (HSE) has recently announced its intention to establish structured care of diabetes in general practice by the end of 2012. A fuller understanding of GPs perceptions of the barriers and facilitators to this proposal is needed to inform transition planning.

Introduction

The prevalence of diabetes is increasing worldwide. The International Diabetes Federation estimates that by the year 2000, one adult in ten will have diabetes. In Ireland, it is estimated that 5% of the population have diabetes of these 1% have type 2 diabetes. Globally there is mounting evidence that a primary care-led health system can provide improved health outcomes at sustainable costs compared to a system centred on hospital care and specialists. Provision of structured diabetes care in general practice, has been shown to provide equivalent standards of care to that achieved by hospitals, with an enhanced diabetes quality of life. In reviewing barriers experienced by GPs to the management of type 2 diabetes patients, four domains emerged, namely patient, practitioner, practice and system factors. A structured diabetes care programme does not currently exist in Ireland. The Irish Health Service Executive (HSE) has recently announced its intention to establish structured care of diabetes in general practice by the end of 2012. A fuller understanding of GPs perceptions of the barriers and facilitators to this proposal is needed to inform transition planning.

Methods

This study used a qualitative descriptive design in which focus groups were used to elicit data from GPs and Practice Nurses (PNs) in Ireland’s Mid-West region. Focus group methodology was chosen to allow the elicitation of opinions, attitudes and beliefs from participants and gain an in-depth understanding of the perceived barriers and facilitators to the effective implementation of a Chronic Disease programme (with an initial focus on type 2 diabetes) in general practice. We recruited practising GPs and practice nurses in Limerick city and county through the GP Continuing Medical Education Network and the Practice Nurses Association. Fifty-five GPs participated in four focus groups and eleven PNs participated in one. A summary of participant and practice characteristics of participants is displayed in Tables 1 and 2 respectively. The Research Ethics Committee of the Mid-West Regional Hospital, Limerick, approved the study.

Each group focus was led by an experienced moderator and used a detailed focus group protocol, whereby a prepared set of open-ended questions guided the one-hour session. All sessions were audio recorded and transcribed. Transcripts were reviewed and themes and emerging themes by researchers working as a team using NVivo software. Qualitative Content Analysis was used to assign codes to passages in the transcribed text. Codes were inductively developed and clustered to answer the research questions. Each transcript was then second coded by another researcher working independently. Theme categories were compared and minor discrepancies were reviewed and discussed until consensus was achieved.

*3 GPs did not provide an answer

Results

Distinct barriers and facilitators emerged in relation to the proposed change in structured diabetes care within general practice and these broadly fell into three domains: practitioner factors, practice factors and systemic factors. The principal barriers and facilitators which emerged are outlined in Table 3 together with the frequency with which these were indicated.

Barriers

Lack of financial incentive
The most frequently cited perceived barrier to implementation of structured care of diabetes in general practice was lack of remuneration. Participants voiced their inability to provide the proposed service without some sort of method of rewarding us. A real concern was that should the proposed structured care of type 2 diabetes be accepted without explicit funding then all other chronic diseases would follow on the same basis “if you do this for diabetes, free gratis, f all of the other chronic diseases will come along on the same basis”.
Lack of access to secondary (specialist) care
Lack of access to secondary care was another key barrier its fine in the practice; its when you send them beyond the practice. Delays in accessing secondary care services were perceived as having a detrimental effect on patient motivation if it takes two years to get an appointment, its very hard to keep them motivated.
Lack of access to secondary care was another barrier “it has to be somebody of registrar standard at least... A deficiency in communication from secondary care was also noted.
Lack of staff and increased workload
Participants underlined the significance of practice nurses to the delivery of diabetes care. However, many GPs, particularly solo practitioners, indicated that the recruitment of a practice nurse would currently not be feasible “I dont see myself being in a position to get a practice nurse anytime soon. The requirement for administrative staff was also perceived as a barrier.

Time constraints
All noted that the demands on their time were ever increasing with many stretched to the limit, e.g. “practices are working independently. Theme categories were compared and minor discrepancies were reviewed and discussed until consensus was achieved.

Insufficient equipment, space & IT resources
A lack of equipment, lack of space and lack of IT were identified as barriers to implementation you need to be able to set up a register and a recall system. It could be an issue for practices that are not computerised.

Lack of protocol
The absence of an agreed national protocol was also seen as a problem “it is important that the best practice... should be laid out first so that everyone would know what it is, and where I am I have patients who go to the Midlands, Limerick and beyond and, they [f] all have their own way of doing things [f] when it should be standardised across the country.

Lack of register/recall system
A major barrier for general practice was the lack of a systematic way to recall or track patients with diabetes through computer systems bringing up the computer register and being able to generate the recalls. Without that it is not going to work.

Facilitators

Access to secondary (specialist) care and visibility
Prompt access to secondary resources was considered a pivotal facilitator to implementation. A clear and visible
referral service was seen as crucial so that they can access them without having to think where am I going to send the patient this time? Will I try private?

Holistic GP relationship & continuity of care
The majority of participants viewed the holistic nature of general practice as a fundamental facilitator. All participants highlighted the importance of the relationships which they have with their patients, their families and social circumstances, we know our patients families so we can check compliance. As comorbidity is common among patients with diabetes this holistic approach is seen as particularly beneficial often these patients have multiple problems anyway, so as a GP you will often pick up on things when they would come in for their diabetes check.

 Provision of HSE resources & education
The provision of HSE resources to support the proposed changes was seen as a facilitator, if the HSE was willing to provide nurses etc. that would be brilliant. The establishment of an education mechanism for both GPs and staff was also regarded as a facilitator.

Provision of funding & financing
Participants clearly noted that for successful implementation, financial backing would be a significant facilitating factor, it all hinges on funding [7] if funding doesn't come, it doesn't happen.

Computerised IT systems
Most participants viewed computerisation as vital for storing information, operating a register and recall system, accessing educational materials, monitoring patient care and conducting audits. A standardised computer programme available to all was seen by many as an enabler.

Discussion
GPs and practice nurses highlighted barriers to the implementation of structured care programme at three levels - practitioner, practice and systems. At the practitioner level, GPs remuneration, time, workload and remaining up to date were key barriers. At the practice level, barriers included under funding, lack of space, IT and staffing. A lack of appropriate funding, lack of time linked with increasing workload has been noted elsewhere as barriers experienced by GPs in chronic disease care [17]. Participants considered that to sustain and support high quality structured diabetes care within general practice would require changes to practice infrastructure that are not always easily implemented. At a systems level, participants deemed poor access to secondary care as a major barrier. It is widely acknowledged distance payments has had a greater effect on rural GPs income and thus their ability to fund extra services such as chronic disease management programmes from existing resources. This concern was shared by many of the participants who are aware of the additional work required for the patient and the impact that it would have on their clinical practice. A lack of appropriate funding, poor communication between hospital and GPs, increase in workload and lack of going access to specialist advice together with lack of skills and education as barriers to effective management also with a Northern Ireland survey of diabetes care management. In Ireland a survey of health priority by participants at the time indicated lack of time, under funding, lack of space and keeping up to date as barriers to provision of good diabetes care. Despite the barriers perceived by GPs a clear sense of motivation and enthusiasm was evident amongst numerous providers I think there is a great will out there in general practice to do the job well.

This study is limited by its sampling approach, whereby participants were all volunteers interested in participating in a diabetes care and geographically based in the Mid-West region of Ireland. Nevertheless these findings shed light on GPs and practice nurses attitudes to implementing a diabetes chronic disease programme in general practice. With only one geographical region in Ireland having a pilot structured diabetes general practice programme in place, our study is likely to be reflective of other regions where chronic disease care in general practice is not formally structured. Also with respect to generalisability of findings, the GP and practice profile of our sample is similar to those reported elsewhere. In conclusion, greater and more systematic involvement of GPs in the care of patients with diabetes is desirable and acceptable to most GPs, but it requires support that will be flexibly matched to the needs of both primary and secondary care services. The need for adequate funding opportunities to facilitate the implementation of structured diabetes care within general practice is an urgent matter. General practice is well placed to deliver structured diabetes care and to realise this potential the provision of the necessary resources is essential, this is without the support of secondary care. But, clinical protocols and training. Further longitudinal research is now timely in order to explore models of diabetes care and evaluate their implementation.

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Acknowledgement
M Fullam, ICGP CME Tutor, U O’Sullivan transcription services (www.leantranscription.com) and L Foley transcription.

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