A practical guide for setting up and managing a diabetes clinic within general practice

JOANNE LOWE. DIABETES NURSE SPECIALIST; INTEGRATED CARE. SOUTH EAST DUBLIN AND WICKLOW

Introduction
Traditionally in the Republic of Ireland, routine diabetes care has been carried out in the secondary healthcare setting. Over the years several successful primary care diabetes schemes have been set up locally, but until recently we have been lacking any national initiatives with reimbursement for this service. With ever growing numbers of patients with diabetes the time has come for structured diabetes care for uncomplicated patients to take place within general practice.

Under the new cycle of care, provision is made for general practice to be reimbursed for care provided for GMS patients with type 2 diabetes, i.e. those holding a full medical card or a GP visit card (as yet there is no provision for private patients). Registration for this process began on September 8, 2015 with the scheme going live on October 1, 2015. For those practices wishing to join, two consultations per patient must be provided per year (one annual review and one routine review). At the end of the 12-month period the annual data should be returned to the HSE via the PCRS system. Whilst this is a landmark achievement for diabetes care in Ireland, some practices may now find themselves in unfamiliar territory in how to go about planning and structuring this service.

Starting up a diabetes clinic in general practice from scratch may seem like a daunting task; however with some forward planning and expert guidance it is an achievable and worthwhile exercise. General practice is the ideal place to screen for and provide on-going care for patients with type 2 diabetes.1

Wagner’s chronic care model demonstrates that “periodic primary care sessions organized to meet the complex needs of diabetic patients improved the process of diabetes care and are associated with better outcomes.”2

How to avoid increasing workloads?
Providing ad hoc diabetes care can increase workload on practice and appointments and may result in inappropriate allocation to both doctors and nurses.

Therefore the role of the practice nurse is vital in primary care diabetes clinics and is key in “encompassing four important elements in care of local populations”3
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• Personal contact with the patient,
• care provision,
• a coordinating function
• Providing flexibility within the service.

What then is required for a successful diabetes service? This article aims to guide you through some of the elements needed, but is not by any means a definitive list.

Provisions required for a diabetes service
• Identify, allocate and protect an appropriate time – protected time is of the upmost importance when setting up a diabetes clinic. Team decisions will be required around a number of areas; how frequently is the dedicated diabetes clinic going to run? How many patients do you have that are suitable for primary care (some complex patients will continue to require either shared or hospital care) and what resources can the practice realistically offer? Which day will the clinic run on and how long will each clinic last? How will you allocate appointments? Fifteen minutes may be long enough for a routine follow up appointment, but 45 minutes may be required for a newly diagnosed patient or annual review.
• Identify adequate space for the clinic – you will probably need two consulting rooms free.
• Identify which staff will be involved in the clinic – GP, practice nurse, receptionists and administrative staffs all have a role to play. It is important from the outset to define clear roles within the clinic.
• Identify educational needs of the staff – do the practice staff need upskilling in diabetes care? Is there formal teaching or courses that you can avail of? Some areas offer sponsored places on established courses. Integrated diabetes care nurses, GPs with a special interest in diabetes and other allied healthcare professionals (e.g. dieticians, podiatrists and pharmacists) may offer informal education on a local level.
• Good record keeping - most surgeries are now computerised. If your practice is not it may be worth the investing in a computer system. Some systems have a specific diabetes template for routine and annual reviews and this can act as a great prompt to help you structure your consultations too. They are also ideal for dealing with paper intensive tasks such as receiving / viewing blood results.
• Development of a live register - a register can be made up of a simple excel spreadsheet; it should include basic details such as name, DOB, GMS number (if applicable) type of diabetes, date of diagnosis and ethnic origin of patient. Some practices prefer to add more information to their registers, however remember the more complex your register the more work it will be to maintain it. Try to keep your register up to date; making changes if patients change addresses, move away or die. Don't leave large amounts of information to build up.
• Develop a call and recall system – identify if there is a member of the team available to help you with the administration of your clinic? You may want to have template letters on file; this makes it much easier than writing a letter from scratch. These can include invitation to clinics or DNA letters. Keep a record of the patient's last consultation date and when you expect to see them again.
• Identify pre-existing patients with diabetes - IT packages such as Health One and Socrates have analysis systems that can help you to easily identify your diabetes patients. If each patient has been coded appropriately this method can be used to search for patients. If coding has not been used, searches via some of the common drugs used, such as metformin, may help you to identify patients.
• Guidelines – practical guidelines for care of patients with Type 2 diabetes are available at; http://www.hse.ie/eng/services/Publications/topics/Diabetes/A_Practical_Guide_to_Integrated_Type_II_Diabetes_Care.pdf
• Screening for and diagnosis of patients with type 2 diabetes – follow established protocols for those patients to screen and for correct diagnosis of diabetes.
• Correct coding of patients – use of correct ICD code for your patients with diabetes. This will help immensely at a later stage for example when running searches or for audit purposes.
• Registering patients for cycle of care – This can be done on the GP application suite/PCRS website, the following information is required;
• GMS number
• Confirmed diagnosis and date of type 2 diabetes
• Confirm practice register contains name, contact details, DOB, gender, GMS number and clinical measures of diagnosis
• Patient’s ethnic group
• Develop a policy for routine and annual review – an annual review should include the following;
• Review and record of blood /urine results (Hba1C, lipids, creatinine and albumin creatinine ratio)
• Discussion of preventative lifestyle factors
• Medication review
• Foot review
• Referral/participation in retinal screening services
• BMI
• Blood Pressure
• Immunisation status (influenza and pneumococcal vaccines)
• Provision of appropriate education materials.

Good diabetes care is not only about data that has to be returned for the cycle of care. “Well treated diabetes involves care
For your patients with type 2 diabetes uncontrolled on metformin

efficacy not yet established. Elderly:
control. metformin is considered inappropriate due to intolerance, or in combination with other glucose lowering
drugs including insulin when these, together with diet and exercise, do not provide adequate glycaemic control and use of
metformin is considered inappropriate due to intolerance, or in combination with other glucose lowering
drugs including insulin when these, together with diet and exercise, do not provide adequate glycaemic control. Dosage: Adults 10mg once daily as monotherapy and add-on combination therapy with other
glucose lowering drugs including insulin. Forxiga can be taken at any time of day with or without food.
Consider a lower dose of insulin or insulin secretagogue such as a sulphonylurea when used in combination
with Forxiga to reduce the risk of hypoglycaemia. Children and adolescents: <16 years: Safety and
efficacy not yet established. Elderly: ≥65 years: No dosage adjustment is recommended based on age.
Renal function and risk of volume depletion should be taken into account. 75 years: No recommended.
Severe hepatic impairment: Starting dose of 5mg is recommended, if well tolerated, dose may be increased
up to 10mg. Contraindications: Hypersensitivity to dapagliflozin, or excipients. Warnings and precautions:
Not to be used in patients with type 1 diabetes mellitus or for diabetic ketoacidosis. Dapagliflozin is not
recommended in patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency,
and related glucose-galactose malabsorption. Lactose: Not recommended in patients with known cardiovascular disease, patients on anti-hypertensive therapy with a history
decrease in blood pressure, which may be more pronounced in patients with very high blood glucose
consentations. Not recommended in patients receiving loop diuretics or who are volume depleted. Exercise caution in patients for whom a dapagliflozin-induced drop in blood pressure could pose a risk, such as patients with known cardiovascular disease, patients on anti-hypertensive therapy with a history

When FORXIGA is used with insulin or SU, a lower dose of insulin or SU may be
considered to reduce the risk of hypoglycaemia. FORXIGA is not recommended
for use with pioglitazone. *FORXIGA is not indicated for weight loss.

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INFORMATION. Consult Summary of Product Characteristics before prescribing.
Presentation: 5mg or 10mg dapagliflozin (as propanediol monohydrate) film-coated tablets. Indications:
Adults 18 years and older: For patients with type 2 diabetes mellitus to improve glycaemic control:
Consider a lower dose of insulin or insulin secretagogue such as a sulphonylurea when used in combination
with Forxiga to reduce the risk of hypoglycaemia. Children and adolescents: <16 years: Safety and
efficacy not yet established. Elderly: ≥65 years: No dosage adjustment is recommended based on age.
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of thiazide and loop diuretics and may increase the risk of dehydration and hypotension. Consider a lower
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diabetes. Pregnancy and lactation: Do not use during pregnancy or breast-feeding. Undesirable events:
Refer to SPC for complete information on side effects. Very common (≥10%): Hypoglycaemia (when used
with SU or insulin). Common (1/10 to <1/10): Vulvovaginitis, balanitis and related genital infections, urinary
tract infection, dizziness, back pain, dypnea, polyuria, haematocrit increased, creatinine renal clearance
decreased, dysglycaemia. Legal Category: POM. Marketing authorisation number: EU/1/2/79/5/002
marketing Authorisation holder: AstraZeneca AB, SE-151 85 S ödertä lje, Sweden.
Further product information available on request from: Freephone 1800 800 899 or contact AstraZeneca
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LOWERS HbA1c with secondary benefit of weight loss*1-3

THE ONLY SGLT2 inhibitor with efficacy and safety data over 4 years4

Experience that counts4-6

1. FORXIGA® Summary of Product Characteristics.
5. Data on file (Cegedim Strategic Data, Longitudinal Patient Databases, January 2015)

Date of preparation: June 2015. Approval ID: 803504.011.

www.hpra.ie
Tel: +353 1 6764971
e-mail: medsafety@hpra.ie
for the person with sensitivity, embracing culture, psychological well being, health beliefs and social structure in an individualised and thoughtful manner. The person with diabetes is central to care planning and is valued, well informed and able to make decisions on self treatment and care."5

- Additional services – are there any other services which you need? This may include phlebotomy and laboratory services. Routine blood samples and urine samples for albumin creatinine ratio should ideally be done two weeks before the patient is due in for their check up.
- Equipment for clinic – basic surgery equipment is required including; a sphygmomanometer, weighing scales and height measure. For foot care a 10g monofilament and tuning fork (or equivalent vibratip). Other useful things include diabetes literature, blood glucose monitors and a variety of appropriate forms including those for long-term illness cards and chiropody services.
  - Emergency box – have everything readily available for when you will need to deal with a diabetic emergency as you never know when they will crop up. It is useful to have an accessible emergency box which is well stocked with equipment to deal with both hyper and hypoglycaemia. Hypoglycaemia is the most common diabetic emergency; a fast acting carbohydrate and/or Glucagon are required to treat it. If hyperglycaemia is present and DKA is suspected, a glucose meter which is able to measure blood ketone levels (with appropriate strips) is required. Please ensure all staff are familiar with the procedure and trained in dealing with emergencies.
  - Identify local services available and how to refer into them – support services for patients with diabetes vary on a regional basis at present. Find out what is available in your area and what is the referral pathway into them. Some services you may find useful are: Local endocrinology team, dietician, podiatry, psychology, weight management and ophthalmology. There is also a variety of structured diabetes group education programmes e.g. X-PERT (www.hse.ie/xpert), DESMOND and CODE. Using these services may save you valuable time on lengthy one to one education sessions and a great way for patients to get peer support.
  - National Retinopathy Screening Service – since 2013 routine retinopathy screening has been available to all patients with diabetes over the age of 12 years on an annual basis. Registration of patients for this service is by a health care professional only; it can be done easily by telephone or on line from the practice. More details of the service and how you can register can be found at www.diabeticretinascreen.ie.
  - Identify local integrated care staff – most areas now have an integrated diabetes nurse specialist. These nurses have great clinical experience and will be an excellent resource in helping you getting things started and providing ongoing support once the clinic is up and running.
  - Develop a policy for audit – it may seem a bit strange to think about audit of a service you don’t yet have, but it will make life easier when you come to perform it.

Conclusion
Cases of type 2 diabetes are continuing to increase. Good quality diabetes care is becoming an integral part of the service provided by general practice and to which the practice nurse plays a central role. Setting up a diabetes clinic within general practice can take time and effort on behalf of all the team but is manageable if approached in a logical and structured manner. The benefits to both the practice and the patient are well worth this investment of time and resources.

References
5. Fox, C; McKinnon, M – Vital Diabetes, Reprinted 2000. Class publishing