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 focus groups. Participants 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 financial incentive (118/631; 19%), lack of access to secondary resources (93/631; 15%), lack of staff and increased workload (59/631; 9%) and time constraints (52/631; 8%). Identified facilitators were access to secondary care (58/631; 9%), enthusiasm of general practice (58/631; 9%). Although barriers are enthusiastic, there remains significant reluctance among GPs and practice nurses to take responsibility for diabetes care without addressing these barriers.

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 have type 2 diabetes. Globally there is mounting evidence that a primary care-led health system can provide comparable 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 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 also recruited care provided by PNs 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 focus group 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 examined for key words 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 derived from the data and were compared and discussed until consensus was achieved.

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 the work. 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, 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; it’s when you send them beyond the practice. Delays in accessing secondary care services were perceived as having a detrimental effect on patient motivation. If taking two years to get an appointment, its very hard to keep them motivated.

Lack of access to appropriate expertise 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 due to the increased workload (59/631; 9%) and time constraints (52/631; 8%). Identified facilitators were access to secondary care (58/631; 9%), enthusiasm of general practice (58/631; 9%). Although barriers are enthusiastic, there remains significant reluctance among GPs and practice nurses to take responsibility for diabetes care without addressing these barriers.

Time constraints

All noted that the demands on their time were ever increasing with many stretched to the limit, e.g. practices are just not in a position to take on extra work. A further barrier was the increased consultation time needed. To do a proper consultation on a chronic disease is going to take double the [normal consultation] time.

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 knows what it is, and where I am I have patients who go to the Midlands, Limerick and Ballinasloe 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
Discussion
GP's and practice nurses highlighted barriers to the implementation of structured care programme at three levels - practitioner, practice and systems. At the practitioner level, barriers included under funding, lack of space, IT and staffing. At the practice level, barriers included under funding, lack of space and keeping up to date as barriers to provision of good diabetes care. At the systems level, participants deemed poor access to secondary care as a major barrier. It is widely acknowledged that the removal of distance code 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 combination with the burden of other diseases also must travel may provide a possible explanation of the differences noted in the frequencies of comments reported by focus group 4 (which included largely rural GPs) on lack of financial incentive and access to secondary resources as barriers to implementation (see Table 3).

Facilitators perceived by GPs in our study included the provision of visible and ready access to secondary (specialist) care in certain areas. Continuity of care and the holistic nature of general practice and were clearly articulated as a facilitator to implementation and have long been seen as a central aspect of quality care. GPs and practice nurses perceived as necessary enablers of implementation. Integrated IT was seen as an important facilitator and has been shown to improve processes of care, prevent complications and generate cost savings. Our findings are consistent with a recent national survey of how GPs manage chronic disease in Ireland which also identified lack of access to specialist funding, poor communication between hospital and GPs, increase in workload and lack of on-going access to specialist advice together with lack of skills and education as barriers to effective management of type 2 diabetes. Participants considered that to sustain and support high quality 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 that the removal of distance code 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 combination with the burden of other diseases also must travel may provide a possible explanation of the differences noted in the frequencies of comments reported by focus group 4 (which included largely rural GPs) on lack of financial incentive and access to secondary resources as barriers to implementation (see Table 3).

This study is limited by its sampling approach, whereby participants were all volunteers interested in participating in a discussion on 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. In general, our 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 the patient and general practice. The proposed changes will inevitably increase workload. General practice is well placed to deliver structured diabetes care and to realise this potential the provision of specific funding for that purpose should be set, together with interventions including extended integration with secondary care, IT, 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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