An Evaluation of Introduction of Diabetes Community Specialist Teams in Two Community Healthcare Networks

Lorna Hurley, Change Manager, Sláintecare Integration Fund, Project 153

Co-Authors

Riordan F, O'Donnell M, Sheehan C, McHugh S, Murphy K, Liew A, Humphreys M, Kennedy D, O'Mahony C, Gleeson M, O'Brien S, O'Reilly O, Dinneen SF

Introduction

- Diabetes prevalence is rising steadily placing an increasing burden on our health services. The traditional hospital-centric model is not sustainable.
- Limited number of integrated diabetes staff (CNSs, Dietitians, Podiatrists)
  - These are rarely co-located, and usually covered large and differing geographical areas
- Alignment of primary care services to new community healthcare networks (CHNs), each with a population of 50,000 people.
- The Sláintecare Integration Fund 2019 presented the NCP Diabetes with an opportunity to pilot the implementation of co-located integrated diabetes teams at CHN level.
- Findings from our qualitative evaluation are presented here.

Aim & project timeline

- The aim of the project was:
  - To pilot the introduction of Community Specialist Teams (CSTs) comprising a diabetes CNS, senior dietitian and senior podiatrist, in 2 newly formed CHNs.
  - To implement the Model of Integrated Care for Type 2 Diabetes and the Model of Care for the Diabetic Foot
  - To evaluate implementation from the perspectives of people with diabetes attending the services, the CST and general practice staff.
- Timeline:
  - The pilot was initially scheduled to run from 09/2019 – 08/2020.
  - Due to Covid 19, the timeline was changed to 09/2020 to 06/2021 (10 months)

Methods: Sites

- CHNs in two different CHOs were selected to represent different diabetes care orientations
- Diabetes care in CHO2 is traditionally hospital-centric whereas diabetes care in CHO4 is largely primary care centric.

CHO2 (CHW)
Network 7
Tuam, Athenry, Loughrea
Population: 58,118
11 GP Practice (40 GPs)

CHO4 (CKCH)
Network 9
North Cork City/Blarney
Population: 50,257
18 GP practices (39 GPs)

Methods: Recruitment

- Six of seven staff members across both sites were successfully recruited
- All were in post by mid-November 2020.

Network 7 base, CHW Tuam PCC	Network 9 base, CKCH St Mary's PCC
CNS ✓	CNS* x
Snr Dietitian ✓	Snr Dietitian ✓
Snr Podiatrist ✓	Snr Podiatrist ✓

Contingency plan:
Two pre-existing CNSs in Cork that had been providing a service within 9 GP practices in the Network joined the team. Hence 9/18 practice had access to all 3 members of the team.

Methods: Service design and implementation

- A strong local governance structure was developed.
- Teams designed their new integrated diabetes services
  - Service eligibility criteria, referral processes, pathways and policies
- Outreach engagement meetings with GPs & Practice Nurses (PNs)
  - 29 general practice across both CHNs
  - Educational updates were incorporated into these meetings
- Integration with aligned hospital specialist team
  - Shared patient information system (Diamond in Galway)
  - F2F and virtual MDT case discussion meetings with consultants
  - Split 80:20 Community-Hospital nature of the CNS

Methods: Evaluation

To assess implementation from different perspectives, a mixed methods approach was used, involving quantitative and qualitative data collection

Quantitative data collection

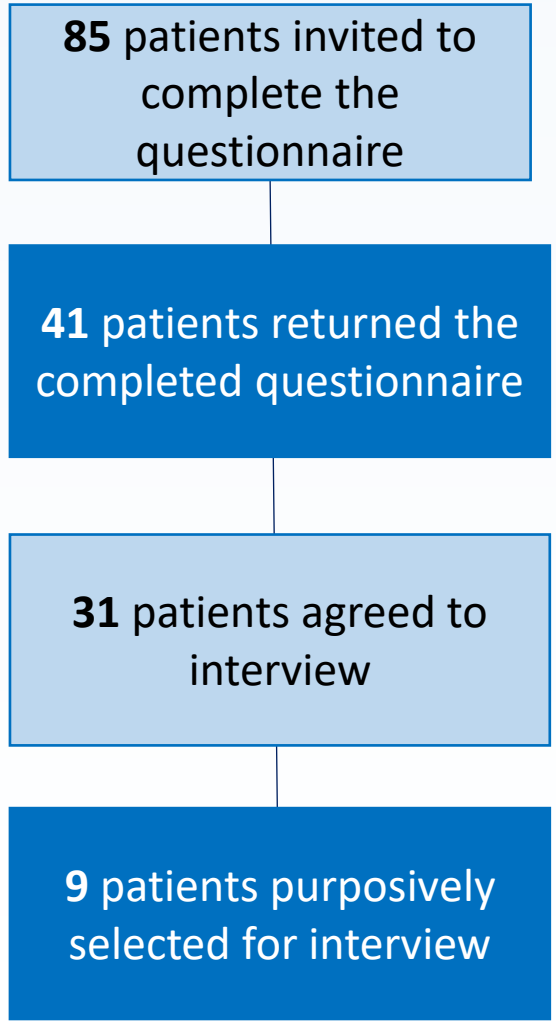
- Monthly clinician activity data
- Quarterly caseload audits

Qualitative data collection:

- Patient experience questionnaire (n=41)
- Patient interviews (n=9)
- Interviews with the community specialist teams (n=7)
- Interviews with GPs (n=3)
- GP practice survey (n=14)
- Focus groups with Practice Nurses (n=8)

Results: Patient Experience

- A total of 85 questionnaires were posted out to people with T2D who had attended a member of the CST during the first 2 weeks in May 2021.
- In total, 41 questionnaires were returned giving a response rate of 49%. No reminders were sent to non-responders.
- Thirty-one people (76%) provided their contact details consenting to be contacted by a researcher to take part in a telephone interview.
- Nine of the 31 who provided contact details were purposively selected based on their responses to the survey questionnaire regarding age, gender, number of appointments and number of CST HCPs they had seen.



Results: Patient Experience

Accessible service

- Short waiting times for first appointment
- Short waiting times on the day of their appointment
- Short distances to travel

Consultation

- Consultations were person-centred (5 item CARE person-centred measure)
- "Enough time" to discuss their diabetes care
- Provided with the "right amount" of self-management information
- Improved confidence in managing their diabetes
- Good level of follow-up support

Communication:

- Between their general practice and the CST
- Between the members of the CST

"I had instant parking…. I was never waiting more than 5 minutes to be called for my appointment….and I have been 2 or 3 hours (waiting) in (outpatient clinic) and trying to park the car at the hospital was unreal…" (Interviewee 04, Female).

"The ladies (the dietitian and the CNS) were on the same page……. it all seemed to work seamlessly…." (Interviewee 02, female).

"She (DNS-integrated care) knew everything about me when I went in, she had everything in there from the practice nurse…."(Interviewee 07, female)

Results: Community Specialist Team Experience

Interviews:

One-to-one interviews carried out by a qualitative researcher with CST members: senior diabetes dietitians (n=2), senior diabetes podiatrists (n=2) and CNSs (n=3)

Facilitators of integrated service delivery

Co-location of the MDT
- ✓ Networking
- ✓ Communication between the team

Outreach meetings with GPs and PNs
- ✓ Facilitated relationship building
- ✓ Opportunity to provide education
- ✓ Ensure clarity on service referral criteria

A shared space
- ✓ Joint appointments
- ✓ Coordinated appointments
- ✓ Case discussions meetings
- ✓ Referral triage meetings

Split (80:20) CNS post
- ✓ Development of a relationship with the hospital team
- ✓ Timely access to specialist opinion
- ✓ Fast tract access for complex cases

ICT systems
- ✓ Shared diabetes Patient Information System (hospital & community)
- ✓ HealthLink e-referral.

Leadership
- ✓ From local governance group
- ✓ From change manager
- ✓ Maintains implementation momentum

Results: Community Specialist Team Interviews

Barriers to integrated service delivery

Lack of administrative staff

X Impact significantly on clinical time

X Impeded organisation of coordinated appointments

X Organising education

ICT barriers

X Lack of access to certain hospital IT systems e.g. iPMS, labs, imaging, Evolve

X Lack of an appointment / scheduling system

X Lack of a recall function

X Lack of automatic reporting of activity data

Lack of clarity on geographical eligibility criteria

X Lack of clarity on network boundaries

X Inconsistency between traditional service eligibility criteria (eligibility by GP address v's Patient address)

Results: GP & PN Experience

Survey, interviews, focus groups

- GP Survey: response rate 14/29 practices (48%)
- Interviews/focus group participation: 11/29 practice (38%) (Focus groups n=8; Interviews n=3)

Facilitators of integrated diabetes care

- Accessibility of the service
- Flexibility of the service
- Direct link to OPD and consultant advice
- Ease of access to expert advice on medication management

Both GPs and PNs commented on the benefit of

- Continuity of care
- Practice nurse support and education

*"The CNS and the team are in contact with the diabetic clinic, she has that link in the hospital, and for those that are very complex, **she can liaise with them in there**. ….. It works well that way". (GP1, Interview)*

*"Often if you phone up the hospital, you could get a different person, I think **knowing who the person is**, helps with the **continuity of care**, and knowing that you can speak to a person directly is invaluable". (GP3, interview)*

*"Through education, and the support of the local team, I think now there is the **confidence to educate the patients**, about their medication and foot care especially. That has been a real change". (PN4, focus group)*

Barriers to integrated care:

X Lack of integrated joined up ICT systems
X Lack of access to labs results
X Inequitable service for non-GMS patients

Preference for location of CNS clinics

- HSE Primary Care Centre = 8/13 (62%)
  V's
- GP Practices 5/13 (38%)

*"What we find, the patient under hospital care, you'd get a letter oftentimes saying they haven't had their bloods done before the appointment, even though we would have done the bloods. But they **wouldn't have been able to access them**.*

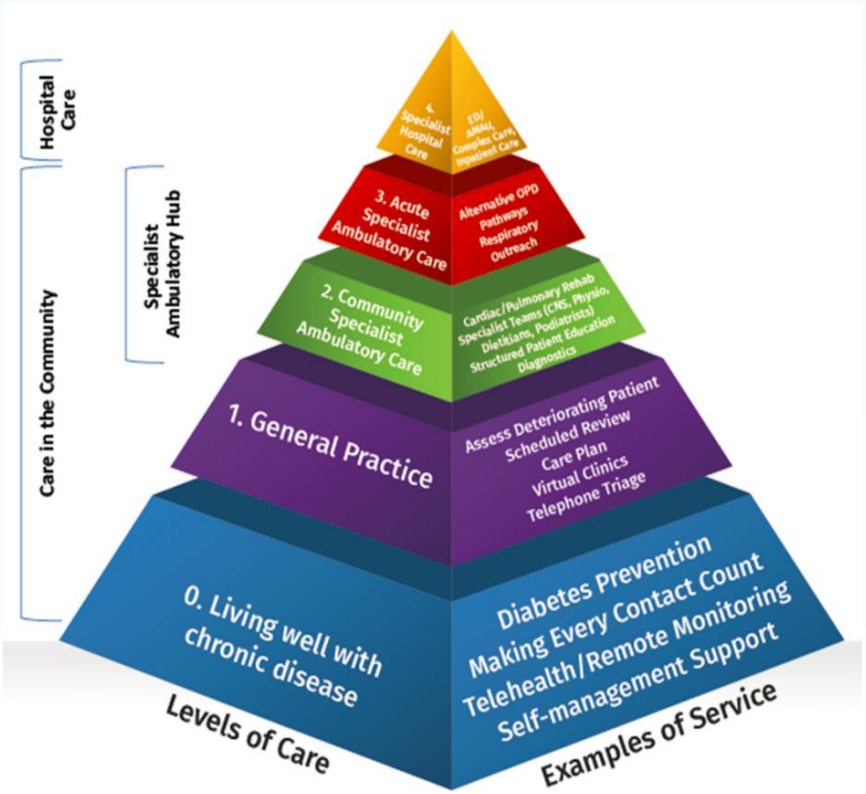
*They'd say 'no bloods received', and would follow up at 6 months again, and that would be the level of input, which is a really regular occurrence. So it's **totally meaningless**, because they wouldn't change their medication…… (GP2, Interview)*

'It is problematic in that you're leaving out a sizeable chunk of the population from the care…….. it would be nice to have the whole population covered.'(GP1, interview)

"I think the private patients are being left behind. They should have the right to access that service (CDM programme) as well." (PN5, focus group)

Conclusion

- This is the first time diabetes CSTs have been established at CHN level
- Our results suggest patients and referrers considered this service to be **accessible, responsive and patient-centered**.
- A set of recommendations have been developed based on the experiences of the CST, general practice staff and patients.
- The learning from the project have been shared with the ECC Steering Group
- Learning can inform national implementation of MOC CDM
  - **Level 2 community specialist ambulatory care**



- Further work is needed to evaluate the clinical effectiveness of this new model.

Acknowledgements

Project sponsors:

Sláintecare

Local project teams:

Community Healthcare West

Cork Kerry Community Healthcare

Research partners:

University College Cork

NUI Galway