POSTER ABSTRACT

Integrated Care in Diabetes: Impact of Email Decision Support on Community Type 2 Diabetes Service in the Midlands in Ireland

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Introduction: In Ireland, significant progress in management of patients with diabetes in the community has been made with the introduction of ‘Cycle of Care’ system. However, the Irish system is still heavily dependent on secondary care for management of patients with type 2 diabetes and integrated care between the community and secondary care remains haphazard.

Since 1998 the Midlands Structured Diabetes Programme has been providing structured care in the community for patients with type 2 diabetes. This involves 3-4 patient visits per year with care being delivered by GP and practice nurse, supported by Community Nurse Specialists. Since 2011 the CNSs have been able to access support from secondary care as part of evolution of the programme to tie in with proposed National Model of Care.

Objective:

1) improve glycaemic control of complex patients with type 2 diabetes
2) lower hospital referral rates and hospital admission rates
3) empower GPs and community nurses to manage more complex patients with type 2 diabetes

Methods: The decision support consisted of specific case emails sent by the community diabetes nurses in Westmeath and Longford to the specialist endocrinologist in Regional Hospital Mullingar, in relation to strategy for improving glycaemic control of individual patients attending different GP practices enrolled in the Structured Care Programme. Data was collected for cases between 2011 and 2016.

Results:

Demographics:

Mean Age: 65 (+/- 12.6)

Gender = 34 Male 26 Female
Glucose control

Mean baseline HbA1c from the year 2011 – 2015 is 61.3mmol/mol [± 15.4, (n=44)].

1 year after the advice, HbA1c improve to 59.1 [±13.3 (n=25)], at 2 years is 62.5mmol/mol [± 13.2 (n=21)], at 3 years is 62.2mmol/mol [± 15.9 (n=17)] and at 4 years is 63.0mmol/mol[± 12.3 (n=20)].

Proportion of patients with improved glycaemic control in 1 year after the advice is 48% (n=12/25), at year 2 is 52% (n=11/21) and in year 3 is 47% (n=8/17)

Complications:

30% (n=18) had macrovascular complications.

15.0 % (n=9) of patients had chronic kidney disease.

10.0 % (n=6) had previous stroke or TIA.

16.7% (n=10) had ischaemic heart disease.

Type of referral

Glucose management: 90.0 % (n=54)

Driving advice: 1.6% (n=1)

Advice on cardiovascular risk: 5.0% (n=3)

Conclusion: Email Decision Support of patients with complex Type 2 Diabetes Mellitus in the community setting leads to improved glucose control and is sustainable and assists in service development and efficiency.

This can potentially be applied to the new ‘Cycle of Care’ diabetes care system in the Irish Health Service.

Keywords: type 2 diabetes; cycle of care; hba1c; midlands