

## Diabetes Management: Results from Physician Survey

December 2002

This survey of the family doctors who provide the best care for patients with diabetes asked the doctors what they do to get such good results. The survey included specific questions on practice size, decision support tools, recall and tracking systems for lab tests, support staff, and requested suggestions on how to deliver optimal diabetes care.

Diabetes mellitus was recently identified by physicians in British Columbia as the top priority for chronic disease management. Accordingly, a provincial diabetes registry has been developed. Patients who received at least two HbA1c tests in the year 2000/01 were identified from the diabetes registry. These patients were associated with the physician who provided the major portion of their primary care services. A list was created of physicians who are responsible for at least 20 patients with diabetes. These physicians were then ranked, based on the proportion of their patients who had at least two HbA1c tests per year. Physicians who achieved  $\geq 70\%$  or better of their patients having these tests were surveyed. This resulted in 88 of the 2,544 physicians (3.5%) on the list being sent a survey on October 28, 2002. As of December 1, 2002, a total of thirty-one physicians responded -- a response rate of 35%.

### Survey Results

#### Practice

Reported practice size ranged from 850 to 4000 patients, an average of 1,680 patients per practice. Twenty-one (68%) respondents reported being full service family practitioners; eleven respondents stated their practices are limited and no longer provide obstetrics. Most respondents (71%) agreed with the reported number of patients with diabetes in their practice, although 22% of respondents thought they were caring for more patients with diabetes than the administrative data indicated.

#### Decision Support Tools

Diabetes guidelines and patient diaries are the decision support tools most often used by physicians and patients. Flowsheets are not commonly used. Over two thirds of the respondents said they always screen high-risk patients for Type 2 diabetes.

DIABETES CARE				
Support Tools	Always	Often	Seldom	Never
Guidelines	13 (42%)	15 (48%)	1 (3%)	0
Patient Diary	10 (32%)	15 (48%)	4 (13%)	2 (6%)
Flowsheets	6 (19%)	4 (13%)	10 (32%)	10 (32%)
Screen Patients	Always	Often	Seldom	Never
Type 2 Screening	21 (68%)	13 (42%)	0	0

## Tracking Methods

<b>Methods for Tracking Lab Tests</b>	<b>Frequency</b>
Prescription & "standing lab orders"	12 (39%)
No method in place	8 (26%)
Use note in chart	7 (23%)
"Follow-up" appointment regime	5 (16%)
Non-computerized list	4 (13%)
Computerized patient tracking	3 (10%)
<b>Methods to Remind Patients of Lab Tests</b>	<b>Frequency</b>
Remind patient during office visit	28 (90%)
Educate patients & proactive scheduling	20 (65%)
Phone	3 (10%)
<b>Staffing</b>	<b>Frequency</b>
RN	7 (23%)
Not specified	2 (6%)
MOA	1 (3%),

Physicians tend to spend time early on to educate patients on their responsibility for self-managing their illness and to plan follow-up visits at 3-6 month intervals. Standing laboratory orders are a commonly used method to monitor patients and keep track of their lab tests (39%). Most of the respondents (90%) use office visits to remind patients they are due for testing and educate (65%) them on the need for regular tests. To streamline care, 65% of respondents typically ask patients to be proactive and have their lab work done prior to their office visit. Prescription renewals are synchronized to last until the next planned visit when the recent lab results are reviewed with the patient. Many physicians indicated that they prefer to educate patients in-person; only three respondents (10%) use a telephone reminder system to alert patients of needed lab work. Very few physicians (10%) reported having a computerized/electronic patient record system to remind them which patients are due for testing.

One third of respondents (11) have additional health care professionals working in their practice, most of whom are Registered Nurses. Respondents stated that the primary role of the RN is to recall patients and to provide diabetes education. Some respondents noted they would like to have an RN on staff to help educate patients but the cost is prohibitive.

### **Delivering Optimal Care**

#### (1) Patient education and monitoring

Approximately one third of respondents (29%) mentioned Diabetes Education Centers as a good source of supplementary patient education. Nine respondents (29%) mentioned that they emphasize the seriousness of uncontrolled diabetes and the important role of the patient in monitoring their own diabetes and changing their lifestyle. One respondent spoke of providing simple and concise written instructions for newly diagnosed patients following a ½ hour consultation.

(2) Staying current on clinical standards

A few respondents cited the importance of staying current through continuing medical education. Diabetes guidelines were also mentioned as important tools.

(3) Supports or resources to enable better care

Respondents had a number of suggestions as to what would enable better diabetes care, including:

- better integration of patients' medical information from laboratory results and hospital based reports with doctor's office records (electronic)
- rapid access to DEC's for nutritional counseling and testing certification
- comprehensive coverage of testing supplies
- a new fee code to compensate physicians for the time and intensity of visit needed for proper disease management.

*A good therapeutic relationship and making the patient the diabetic 'expert', then they take responsibility for their care. (Respondent #12)*

*Patient interest and motivation are the key hurdles. (Respondent #7)*

(4) Barriers

Walk-in clinics were cited as a barrier to quality diabetes management because they offer "convenience visits" which can result in duplication of services, including repeat laboratory testing. As well, the lack of comprehensive coverage of diabetes testing and treatment supplies was cited as a barrier to good care.

*The lack of comprehensive coverage for diabetes testing supplies and treatment, often contributes to sub optimal self-monitoring and adherence to treatment recommendation. As with programs in European countries we need to support diabetic individuals in obtaining self-testing and medical treatment to improve compliance. (Respondent #5)*

**Summary of comments**

The overwhelming majority of respondents reported using essentially the same techniques for tracking patient testing, patient reminders, and methods for delivering optimal care. Respondents suggest it is important to spend time early on to educate patients on diabetes and to encourage patients to take a proactive role in diabetes management. Physicians want patients to take ownership of their disease and to take an active role in its management. A common strategy used by physicians is to synchronize follow-up visits every three to six months with the patient who has lab work done ahead of time; lab results are discussed, patients are educated and prescriptions renewed in one visit. This technique seems to be efficient and effective. Respondents to this survey are the high achievers for monitoring diabetes-- the top 3.5% of doctors responsible for 20 or more patients with diabetes, yet it is clear from the responses that many of them would like to provide even better care.

***What supports or resources would enable even better diabetes care?***

*Better doctor education facilities; it is practically impossible to get a locum so I can attend [diabetes] courses. Feedback-- like your letter [is helpful]. I hoped with my approach to get 90% figures across the board- so I need to improve. (Respondent #4)*

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