Collaborative DM Patient-Care Program between Family Physicians and Diabetologists:

A Pilot Model to Enhance Management of DM at Primary Care Level

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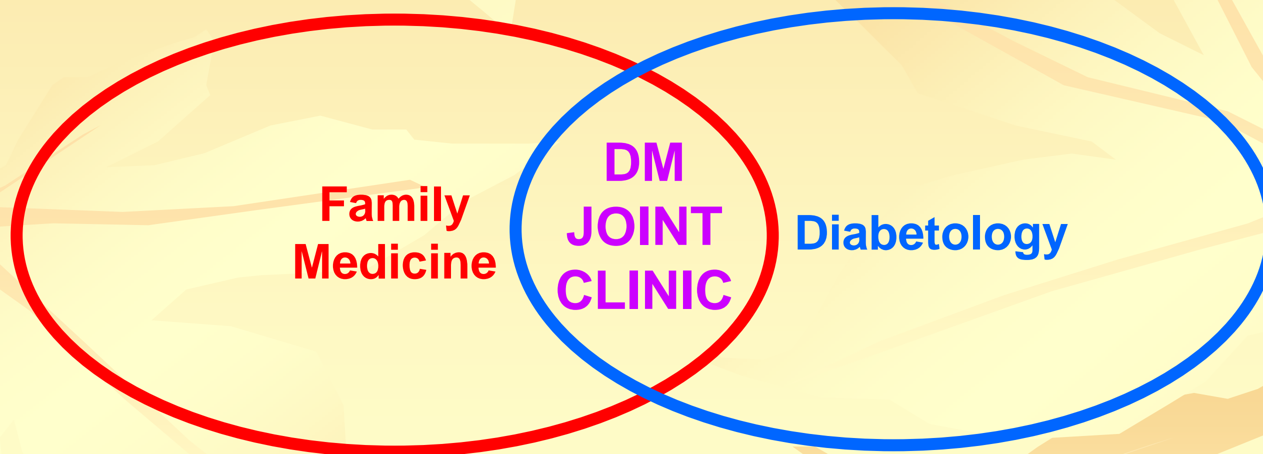
DM Joint Clinic

- Started in 2006
- Collaboration



- Quality and easily accessible service

Objectives

- To prevent complications development amongst GOPC's DM patients by providing early joint intervention in selected high risk or problematic cases

- To empower GOPC staff in high level DM care

- To relieve the patient load to SOPD

Target Patients

- Resistant cases (e.g. secondary oral drugs failure)
- Patients with drug or diet compliance problem
- Patients with fluctuating H'stix profile (i.e. recurrent hypoglycaemia or hyperglycaemia) despite with good compliance

Getting Started

- Training of family physicians by diabetologists
  - Tactics in assessing patients with suboptimal DM control
  - Skills in insulin initiation and subsequent dosage titration

- Training of GOPC nurses by nurse specialists
  - insulin injection techniques (to teach patients)

The Program

- DM patients requiring initiation of insulin will be assessed in a designated session each week in our clinic by trained family physicians and nurses

- In our experience, most patients could be smoothly maintained on insulin treatment after 3 visits

Case Sharing

- 59/M, Construction site worker
- Hx of DM since 1988.
- On maximum oral hypoglycaemic agents:
  - Metformin, Daonil, Avandia
- HbA1c:
  - 2/2007: 9.9
  - 9/2007: 11.6
  - RFT: normal

Case Sharing

- Seen in DM Joint Clinic in 2/2008
  - Ruled out occult infection
  - Assessed his will and feasibility of self-insulin administration
  - Taught on technique of insulin injection (using penfill)
  - H'stix profile keeping
  - Re-education on diet control and meal planning

Case Sharing

- Put on insulin since then, starting from Protaphane 18u om + Metformin
- Subsequent gradual titration of protaphane to 26u om (current dosage)
- Improvement shown in HbA1c:
  - 1/2009: 9.2
  - 6/2009: 6.9
  - 9/2009: 6.7

On-going Development

- Joint Clinic sessions by family physician and diabetologist every 3 months

- More complicated DM patients were seen by family physician and diabetologist together in the same visit to formulate the most suitable management plan

On-going Development

- Allows continuous care by family physicians and input from diabetologist in one setting
- Saves patients’ time in queuing up for SOPD

Communication between Family Physicians and Diabetologists

- Drafting of patient selection criteria into the program
- Having regular discussion with diabetologists in our selection criteria to this joint clinic
- Setting clear guidelines of direct referrals to the DM Centre of QMH (Proper triage system)

Results

As of December 2009

- Over 100 patients had been seen in the whole program
- 58 patients had been successfully put on insulin in SYP GOPC
- Mean age: 62, ranging from 44 to 81 years old
- Average pre-treatment HbA1c was 9.8%
- 61.5% of these patients had shown progressive improvement in HbA1c
- Amongst those who showed improvement, 75% had more than 1 unit (%) sustained reduction in HbA1c levels after 6 months post insulin initiation
- Only 2 patients (3.5%) required subsequent referral to the secondary hospital level for management of resistant DM conditions

RAMP

- Risk Factor Assessment and Management Program (a comprehensive chronic disease management program in primary care)
- For HKWC, it would be implemented in the year 2010-2011 for DM
- The DM Joint clinic serves to enhance our preparation to this larger project in the near future

Conclusion

This program:

- Successfully enriches our GOPC staff's skills in initiating insulin injection
- Empowers us to manage more complicated DM conditions
- Prepares us to meet the growing needs of holistic DM care amongst our population

Our Team

Thank You!