

National Divisions Diabetes Program



**The structure & organisation of
Division diabetes & CVD programs**
– results from a quantitative survey

National Divisions Diabetes Program
Divisions Diabetes & CVD Quality Improvement Project

*Divisions improving quality of care &
health outcomes in chronic disease*

November 2003

1.0 Purpose of the study

The study aimed to collect and collate quantitative information from participating Divisions about the structure and organisation of their diabetes and/or cardiovascular disease programs. Using a survey instrument, the study investigated Division program activity across the following headings: Division size, general practice population, program activities, Division-based register-recall systems, practice support, program management, target groups, education and quality improvement and models of care.

1.1 Methods used

The study identified 104 (out of a total of 121) Divisions of General Practice who had reported the existence of a diabetes and/or CVD program in the *2001-2002 Annual Survey of Divisions (ASD)*. In October 2002, these Divisions were invited to participate in the study if they had a diabetes and/or CVD program in accordance with a policy framework established under the NDDP Data Collation Project ensuring that participation was voluntary and that Division data would be used to contribute to quality improvement and feedback mechanisms. On the basis of feedback from Divisions, the project team found that at the time, 101 Divisions had a diabetes program and 70 a CVD program.

Divisions were invited to participate by mail. Seventy-nine (78%) eligible Divisions with a diabetes program and 39 (56%) eligible Divisions with a CVD program agreed to take part in the project. Participation involved Division diabetes and/or CVD program officers responding to a survey designed to capture a broad range of information about Divisions programs.

1.2 Key findings

- Eighty-one Divisions participated in the DDCQIP survey. Eight-five percent (47/55) of eligible metropolitan Divisions and 65% (34/52) of eligible rural Divisions were involved in the survey.
- The study found that there is a significantly greater proportion of accredited practices and practice nurses within rural Divisions.
- Divisions found it difficult to provide reliable data about practice IT systems.
- Divisions that provided accreditation support to practices had a significantly greater proportion of accredited practices within their Division area.
- Thirty-one Divisions (39% of the survey) had a diabetes register/recall system and nine (20%) had a CVD register/recall system. There was a large increase in the number of active diabetes patients from 11074 (191 for CVD) in 2000 to 25175 (432 for CVD) in 2002. There was also a corresponding significant increase in the GP/active registered diabetes patient ratio from a median of 27 in 2000, to 35 in 2001, and 42 in 2002.
- Divisions that maintained registers were significantly more likely to provide de-identified results of clinical audit activities to practitioners, practices and to their Division Board/Executive.
- There was an increase of 25% in registered diabetes patients between 2000-01 (n=4119) and 2001-02 (n=5147). Seventy-seven percent of the rise in 2001-02 occurred after the introduction of National Integrated Diabetes Program on 1 November 2001.

1.3 Detailed findings

Division and GP population characteristics:

- The states that had the highest participation rate were Tasmania with 100% of its eligible Divisions, NSW (82%) and Victoria (78%). The lowest rates were from ACT (0%) and Northern Territory (50%). Figure 1 shows the comparison of rural and metropolitan participation and figure 2 displays the component parts of CVD programs.

Figure 1: Diabetes and CVD programs

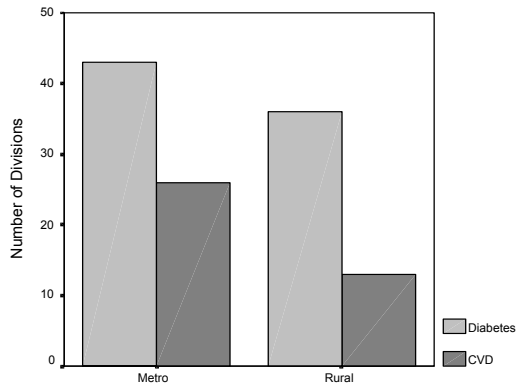
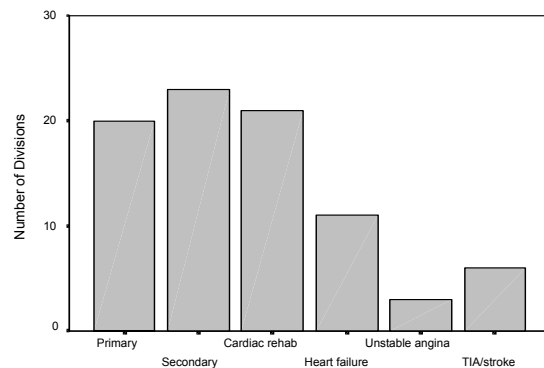
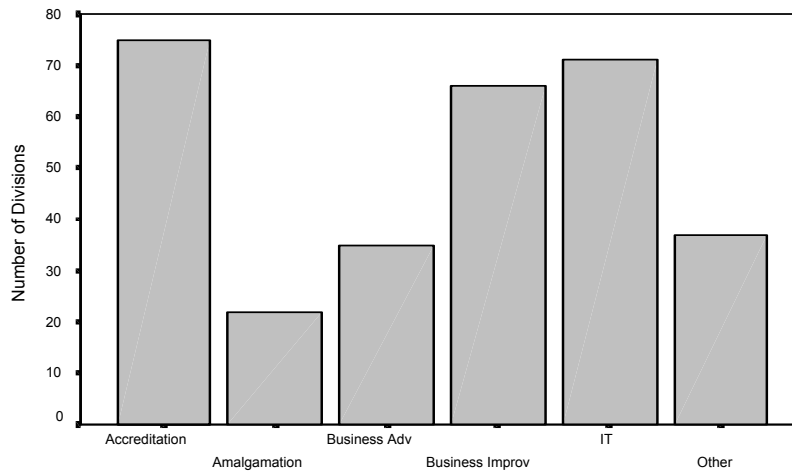


Figure 2: Components of CVD programs



- The study sample recorded a median number of 171 (range 12 – 625) general practitioners for Divisions. The median for rural Divisions was 79 (12 – 322) and for metropolitan Divisions it was 248 (64 – 625).
- Rural Divisions have greater proportions of accredited practices than metropolitan Divisions. Seventy-eight percent of all practices in rural Divisions were accredited and 55% of all metropolitan practices were accredited. This finding was replicated when Divisions were compared by the proportion of accredited/total number of practices per Division ($t = -3.903$; $df=75$; $p < 0.0005$).
- Divisions found it difficult to provide reliable and consistent data about practice IT systems. In some cases over half of all participating Divisions were unable to provide any figures.
- Sixty-six Divisions were able to provide figures about the number of practices using practice nurses. The results showed an overall Division median of 17 practice nurses. These results are comparable with ASD figures for 2001-2002, which showed a median of 19 from data from 76 Divisions. The survey figures also showed a significantly greater proportion of practice nurses within rural Division ($p < 0.001$).
- The practice support activity that Divisions are most involved in was practice accreditation (25%) followed by IT (23%) and HIC Business Improvement (22%). Thirty-seven Divisions also specified other activities which included Enhanced Primary Care and support to practice nurses and practice managers. Divisions recorded that the delivery of support was mainly through practice visits.

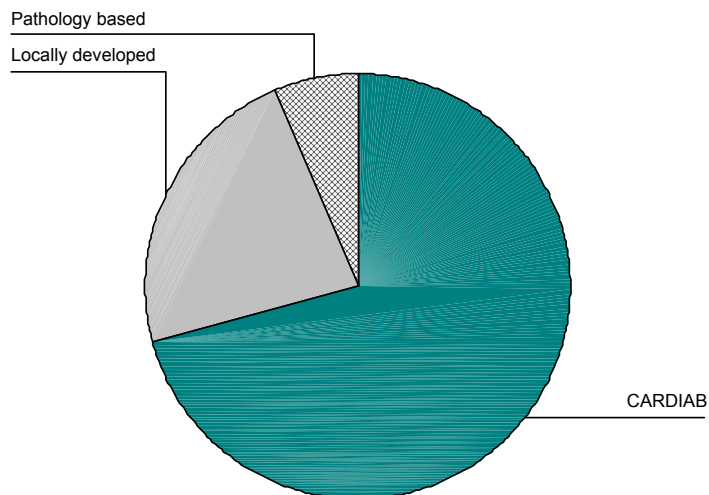
Figure 3: Division support to practices



Division-based register and recall systems

- Thirty-one Divisions (39% of survey) recorded the existence of a Division diabetes register/recall system. Eight Divisions (20%) recorded a CVD register/recall system. Most of these register recall systems were CARDIAB (71% diabetes; 50% CVD; see figure 4). Twenty-eight Divisions provided data about the number of GPs with diabetes registered patients in 2002. In 2002 there were 1318 GPs with diabetes registered patients a marked increase from the figure of 908 in 2000. The corresponding figures for CVD showed a rise from 85 GPs in 2000 to 384 in 2002. The survey shows a large increase in the number of active diabetes patients from 11074 in 2000 to 25175 in 2002. In CVD the rise was from 191 in 2000 to 432 in 2002

Figure 4: Types of Division register/recall systems



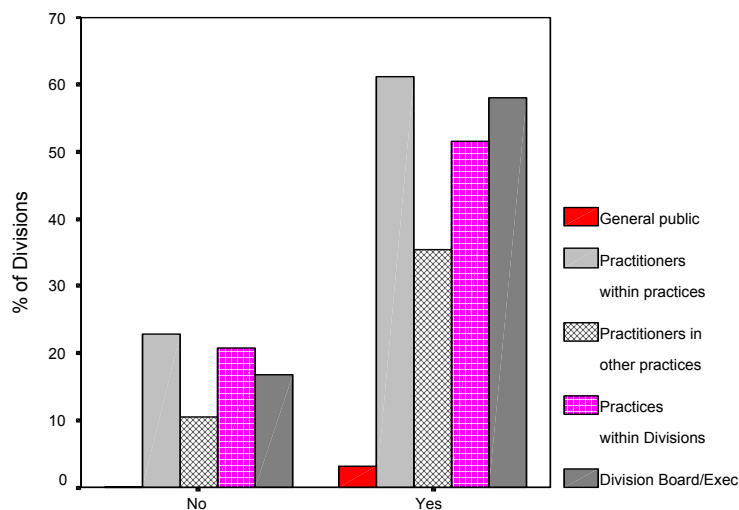
Practice support and program management

- Enhanced Primary Care is the area in which most Divisions (95% diabetes programs and 77% CVD programs) provide support to practices. Other areas where Divisions provide high levels of support are Practice Incentive Programs and practice registers. Sixty-five percent of Divisions with diabetes programs (46% CVD) targeted one or more of the following groups: Indigenous population, non-English speaking background, youth, older persons, lower socio-economic groups, refugees, other ethnic groups. The majority of Divisions also reported that they targeted one or more of the Smoking, Nutrition, Alcohol, Physical Activity (SNAP) risk factors.

Education and quality improvement

- Ninety-six percent of Divisions with a diabetes program (n=79) recorded that their program provided Continuing Professional Development (CPD) for one or more of the categories: GPs, practice managers, practice nurses/educators, other practice staff, other Division staff. Of these Divisions 100% reported that they provide CPD for GPs, 84% reported it for practice nurses/educators and 56% for practice managers. When Divisions were asked what was the most critical education activity in their Division program, most (56% diabetes; 70% CVD) recorded CPD events followed by dissemination of guidelines (11% diabetes; 14% CVD). When Divisions were asked what was the most critical education activity in their Division program, most (56%; diabetes; 70% CVD) recorded CPD events followed by dissemination of guidelines (11% diabetes; 14% CVD).
- Fifty percent of Divisions with diabetes programs recorded that they provided clinical audit results to one or more of the following: general public, practitioners within practices; practices within Divisions and Division Board/Executive (see figure 5) The data showed that most of those Divisions involved in one or more of these activities had Division registers (p<0.05).

Figure 5: Who do Divisions (diabetes program) make clinical audit data available to compared by whether or not Division has a register



- Practice nurses (68%) endocrinologists (81%), dietitians (67%), nurse educators (73%) and podiatrists (65%) were reported as participants in Continuing Professional Development events provided by Divisions with diabetes programs (n=79). Sixty-seven percent of rural Divisions with diabetes programs received external funding. The corresponding figure for rural Divisions with CVD programs was 54%.
- The model of care that most Divisions chose as the best description of their diabetes and/or CVD program was multidisciplinary team (where the GP refers to a defined network of specialists and allied health providers). Miniclinics (GP sees patients at set session times and a nurse, specialist, dietitian, podiatrist are present at the clinic) tended to show up more prominently among: a) Divisions with diabetes programs b) rural Divisions and c) in the higher disadvantage grouping. Divisions (with diabetes and/or CVD programs) with registers had a higher proportion of the structured shared care models linking hospitals, specialists and allied health with common protocols and guidelines.

1.4 Implications

Consumers:

The results of this survey showed a significant increase in the numbers of register patients across diabetes over the years 2000-2002. This means that there is an increased likelihood of patients diagnosed with diabetes and/or CVD, will be part of a register-recall system.

The survey revealed a range of specified Division population health initiatives and activities. A high proportion of Division programs (65% diabetes and 46% CVD) were specifically targeted at one or more population groups, these included Indigenous people, non-English speaking background, older persons, lower socio-economic groups. The majority of Divisions also reported involvement in activities related to one or more of the SNAP (Smoking, Nutrition, Alcohol, Physical activity) risk factors.

GPs:

Continuing Professional Development activity is a key part of Division program activity, along with dissemination of guidelines, clinical audit and group learning.

GPs involved in Division based registers were more likely to be recipients of audit results for use in quality improvement.

Divisions:

The results of this survey show the scope of Division program activities, including the aim of improving practice capacity in the areas such as IT, practice accreditation, practice nurses and practice managers.

The survey showed that Division support to practices was highly concentrated in the areas of accreditation and IT. This survey revealed a significant correlation between levels of practice accreditation and Division support. There is a similar correlation between Division IT support and the uptake of SIP as shown in comparisons with Health Insurance Commission data (see report in this series '*Uptake of NIDP Incentives*').

Division register recall systems can have a major role in promoting population health activity and in quality improvement.

Division programs in diabetes and CVD promote collaboration across health sectors and for building strong alliances with service providers.

The survey showed that Divisions may not be as well-informed as they could be about some important characteristics of their GP population, in particular IM/IT utilisation and GP demographics.

Policy makers:

The National Integrated Diabetes Program has impacted on the number of active registered diabetes patients and in the increase in the number of Division registers in the period 2001 to 2002.

The survey reveals the effects on Division planning of some key Commonwealth rural initiatives eg More Allied Health Services, Enhanced Primary Care, Practice Nurse Program and the Chronic Disease Management Program (see '*Uptake of NIDP Incentives*' report in this series).