Checking 'Get Checked'

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ABSTRACT

Background

South Link Health Inc. (South Link) has provided organisational management of the *'Get Checked'* Diabetes Annual Reviews in its members' practices since 2000.

Aims

To assess the sustainability of the *'Get Checked'* programme for the general practitioners (GPs) and practice nurses who make it work.

Methods

A postal survey of South Link members was conducted with fax-back return of completed forms. Closed questions were used for data about practices and open-ended questions were used to solicit views on the best and worst parts of the current programme's operation, and how it might be improved.

Results

Ninety-eight responses were received (46.7% response rate). The best aspects of the *'Get Checked'* programme were that it provided time to focus on managing a single complex condition, it was adequately funded, and the programme supported more consistent care that encouraged better patient education and made patient care through the rest of the year easier. The worst aspects were usually operational: timing of the check and accompanying tests, accessing referred services, and dealing with the paperwork generated by the programme. There was also uneasiness over perceived lack of individual benefit to participating patients and tick-box forms misrepresenting the standard of care provided. Suggestions for improving *'Get Checked'* included demonstrating benefits and costs of the programme to individual patients and providers, dealing with the practical challenges of providing the checks (for example, by improving access to referred services such as retinal screening), and streamlining administration.

Conclusion

The administrative load of the programme and the tension between the population-based approach of *'Get Checked'* and the general practice core value of patient-centredness are issues for the sustainability of *'Get Checked'*. Strategies to bridge the gap between individual patient and population goals need to be developed. There should be a comprehensive plan for general practice-relevant research using the collected data.

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Introduction

Each year New Zealand's general practices see more than 80% of the people living in the country – more than any other health service or sector and more than three times the number of people receiving care in hospitals.[1] Given this, it is not surprising that general practice should be viewed as the most appropriate vehicle for delivering population-based health services such as screening programmes, despite potential conflicts with the core general practice value of patient-centredness.[2]

Facing compelling evidence of the current and projected burden of diabetes in New Zealand,[3,4] in 2001 the government launched the diabetes *'Get Checked'* programme. Although there is a substantial problem with undiagnosed diabetes (because treatment is most effective when it is provided early), *'Get Checked'* is different from other screening programmes (cervical cancer, mammography) because its focus is on constraining disease progression in already diagnosed patients rather than identifying patients with previously undiagnosed diabetes. The programme provides a free annual visit to their GP for patients with diagnosed diabetes. During this visit a standard set of measures is collected from each patient and prompts to provide 'evidence-based best practice' in diabetes care check that recommended interventions and processes are at least considered (Table 1 lists the elements of annual reviews).

South Link Health Inc. (South Link) has managed the *'Get Checked'* data collection for its members' practices since the programme's start. When South Link receives the completed *'Get Checked'* visit form, payment is processed for the practice and patient data are entered onto a database. This database now holds more than 60 000 records of around 21 000 people who have had one to seven *'Get Checked'* annual reviews.

The South Link database is used for both practical management of the programme (including payment processing) and for research.[5-7] Electronic triggers prompt the production of pre-populated forms that are sent to practices when patients' next annual reviews are due. Reports providing relevant feedback and comparisons of demographic, clinical, and treatment information are generated for individual general practitioners, general practices, Primary Healthcare Organisations (PHOs), and District Health Boards (DHBs).

In 2006 we surveyed South Link practices to assess whether the *'Get Checked'* programme in its current form meets the needs of doctors and nurses providing patients' diabetes checks and to determine if these people who make the programme work considered it sustainable. The survey form also solicited ideas on ways to make it easier for patients to participate in *'Get Checked'* and for general practice to provide the service. This paper reports the results of that investigation.

Methods

To encourage response, the survey form was sent to each of the 210 South Link member practices on a single double-sided sheet of paper. We aimed to qualitatively characterise the range of views in South Link about *'Get Checked'* so we did not randomly sample from the group of South Link practices as we would have for epidemiological research. Survey forms were returned via toll-free fax. Non-responders were not followed up.

One side of the survey form outlined the reasons for the survey and presented a list of 65 extra variables that have been proposed for collection at *'Get Checked'* checks. Respondents were asked to tick the variables that they would be prepared to report. The reverse side asked respondents to list the single worst and the three best things about the current *'Get Checked'* programme: we expected these 'best' and 'worst' things to relate to the experiences of doctors and nurses in delivering the programme, rather than to perceived health outcomes for patients – but the latter were also possible. The form also invited speculation about reasons for non-participation in *'Get Checked'* among people with diabetes in their practices. Further observations about the *'Get Checked'* programme were invited in a general comments section.

The analytic approach was first to compare responding and non-responding practices with respect to their rural and DHB location. We

Table 1. Content of annual 'Get Checked' reviews

The annual review must include:

- Review of symptoms and concerns of the person with diabetes and/or their whanau.
- Examination of risk factors and complications. This must include a foot examination and advice about basic foot care.
- Fasting blood test for cholesterol.
- Blood test for HbA1c.
- Urine test for early nephropathy (albumin/creatinine ratio).
- Review of medications the person is taking or may need to take.
- Development of a Care Plan.
- The person's consent for the clinical information collected to be used to improve health care through confidential feedback to health professionals and research on aggregated data, in which the person remains anonymous.

Completion of the above tasks is noted on the annual review form. The form also includes demographic (date of birth, sex, ethnicity) and clinical (blood pressure, cardiovascular history) information about the person.

made lists of the written responses to questions about the best and worst things about *'Get Checked'*, and general comments, grouping similar responses into themes. We then ranked the 65 proposed additional data elements according to the number of times each variable was ticked.

Results

Ninety-eight responses were received out of 210 surveys sent out (46.7% response rate). There were no differences in response rate between the five DHB regions included in the survey.

All responses came from members who participated in the South Link diabetes programme and 70 (71.4%) participated in the Diabetes Enhanced Management programme that focuses on lifestyle and medication change for people with two consecutive HbA1c measures above 8. Reasons for not participating in the Enhanced Programme included time and space constraints and *'limits to how much of this sort of thing we can squeeze into a day'*. Two respondents indicated they would participate in the enhanced programme (*'would definitely be interested'*) but did not have the forms. Almost all respondents (93.9%) indicated that their practices maintained a register of patients with diabetes: 42.9% had an up-to-date practice diabetes register of their own design; 28.6% used the South Link Diabetes Programme register, and 22.4% used both. In the practices of 65.3% of respondents, both GPs and practice nurses completed diabetes reviews; for 24.5%, only GPs completed reviews; and for 8.2%, only practice nurses completed reviews.

Table 2 summarises the participants' views of the best and worst parts of the South Link *'Get Checked'* programme.

Table 2. Best and worst parts of the South Link 'Get Checked' programme

Best parts	Worst parts
• Having dedicated time to focus on managing a single complex condition • Adequate funding • Consistent diabetes care because of the protocol and South Link resources • The regular checks on their health status make patient care through the rest of the year easier • Diabetes data aggregated and fed back to doctors and practices has educational benefits • Downstream effects result in improving other practice systems • More detailed patient education is possible, leading to patients learning more about diabetes and taking more responsibility for their health	• Persuading patients to return for annual checks, especially hard-to-reach patients and those with poor glycaemic control • Finding time to actually provide checks • Accessing referral services, especially retinopathy screening • Programme processes fail to acknowledge patients' choices and care decisions • Insufficient influence of emerging research on the *'Get Checked'* programme • Completing a form could be seen (wrongly) as a proxy measure of better care • A perception that individual patients do not actually benefit from the checks in terms of improved health status • Administrative problems, including: – More paperwork – Problems with computerised reporting – The rigidity of timing of the check – Complex administration – It is hard to complete all parts of the form for some patients, e.g. rest home patients – Holding partly completed forms until lab test results arrive

Best parts of 'Get Checked'

Eight respondents (8.2%) did not express their views of the best part of the programme. The other 90 respondents provided 108 comments. From these, the most valued aspects of *'Get Checked'* were that it provided time to focus on managing a single complex condition (*'the one visit per year where the diabetes is concentrated on'*), it was adequately funded, and the programme supported more consistent care. Adequate funding meant that the checks were usually free – financial barriers that could discourage patients from having a regular diabetes-related check-up were considerably reduced (*'free annual visits for diabetes does persuade some to come who otherwise wouldn't'*). Consistent diabetes care was supported by the *'Get Checked'* protocol, checklists, prompted reminders, and South Link feedback. These resources ensured that *'...things don't get forgotten'*. The regular checks of their health status provided opportunities for detailed patient education targeting individual patients' knowledge gaps, especially those relating to diet.

The *'Get Checked'* programme also delivered educational benefits to doctors and nurses. Reports of aggregated data from *'Get Checked'* were fed back to doctors and practices and allowed them to see the progress in diabetes care achieved over time by their own and other practices. This in turn facilitated individually-relevant learning. A further observation was that systema-

tising care for one group of patients had downstream benefits in improving care for other patients (*'promotes better review of all [practice] systems'*).

Worst parts of 'Get Checked'

Fifty-four respondents provided 55 comments on aspects of *'Get Checked'* that they found most problematic. The practical problem most often cited was in persuading patients to return for annual checks, especially 'hard to reach' patients and those with poor glycaemic control (*'...poorly controlled diabetics remain hard to convince'*).

There were also practical problems with actually providing the checks. The half-hour consultations had to be accommodated within busy doctor and practice nurse schedules. Having patients return for a second visit to receive laboratory test results and revised management options because of these results was a routine process in many practices and it was problematic because two visits had to be scheduled rather than the single visit assumed by the programme. Some patients also had routine diabetes checks at hospital outpatients clinics: these patients often became confused about the place of general practice checks in their care management (*'people think because they have a check-up at the hospital they do not need to see their GP'*). Observations were made of poor integration of care and little information sharing between hospitals and general practices.

'Get Checked' prompts actions such as medications review and referral to other health care providers such as ophthalmologists and podiatrists. Retinal screening is a 'best practice' procedure that often had to be skipped (especially for rural patients) because of lack of availability.

Administration problems included the perennial problem of extra paperwork generated by the programme, the rigid timing of the annual check (to be paid, annual checks have to be completed within six weeks of the due date), problems with electronic reporting (*'software does not keep pace with additional information required: software should be in place before the information is required'*), and the complexity of administration procedures in general. Sometimes the information sent from South Link about patient recalls did not match with the practices' information, causing frustration in the practices. For some patients (e.g. rest home patients) it was hard to complete all fields in the form.

Some comments expressed concern highlighting the differences between population-based and general practice perspectives. The respondents, who are all in clinical professions, felt that managerial interpretations of *'Get Checked'* forms were only rough approximations of patients' clinical reality, but the bureaucracy's perspective was dominant: *'Ticking boxes changes the emphasis from patient care to filling out a form correctly, puts the emphasis on an annual review whereas in reality management is reviewed with every visit i.e. >4 times a year'*. It is a problem for some to complete the form as a proxy for providing better care, especially when the form fails to acknowledge patients' choices and care decisions that may not align with 'best practice' from a population viewpoint but are 'best' for the individual patient concerned. A related problem was a perception that for many individual patients, their health status does not actually improve from the checks: *'Lots of patients feel very little benefit from the actual check'*; *'We are not treating our patients any differently from how we used to, but are filling out more forms and in some cases (e.g. terminally ill diabetes) form filling just for form filling's sake.'*

The most valued aspects of 'Get Checked' were that it provided time to focus on managing a single complex condition, it was adequately funded, and the programme supported more consistent care

Improvements to 'Get Checked'

A wide variety of suggestions to improve *'Get Checked'* was made by 33 respondents. Only one respondent wanted to be paid more for participating in *'Get Checked'*. Another said more pay was needed only if more documentation was sought, and others commented that it was important the checks remained free.

Several changes to the data collection form were suggested, including gathering more information (generally). Specific data some respondents volunteered to collect were: ACE intolerance, changes in medication, whether the patient was included in the practice's 'capitated' population, diet and exercise habits, and waist measurement.

Suggested improvements to *'Get Checked'* administration were: ensuring that the overdue lists include only genuinely overdue people, making annual check dates more flexible, sending annual check reminders directly from South Link to patients, and funding two to three hours of patient education at the initial check. There were several comments that current electronic claiming and documentation were excellent, where they were available.

Non–participating patients

Thirty respondents (30.6%) did not indicate why they felt patients in their practice were not involved in *'Get Checked'*. Of the remaining 68, 15 (22.1%) indicated that all patients with diabetes were involved in the programme except two children who received three-monthly reviews at hospital paediatrics clinics. One other respondent indicated that although all known diabetics in the practice were enrolled, the practice had a *'huge population of IFG/IGT patients'* and more advice about care for these patients would be useful.

Reasons for non-participation fell into three natural categories:

1. Patient non-participation for unknown or speculated reasons including apathy, denial, difficulty keeping appointments because of inability to get time off work or mobility problems, refusing to have blood tests, simply exercising their right to choose, and general non-compliance with medical regimen. Some patients thought they had good control by their own management and did not need the extra attention of the *'Get Checked'* programme. (43 comments)
2. Failure of practice systems, usually forgetfulness of practice staff. Other barriers to engagement were practices being closed in the weekend or not part of PHOs. (12 comments)
3. Patients under the care of other providers such as hospital specialists or Maori providers. (10 comments)

Preparedness to collect further data

Half the survey respondents did not list any further data elements they were prepared to collect. Of the others, waist circumference was more often perceived to be useful than any other variable (49 respondents (50%) would willingly report this measure). Patients' feet circulation and history of angina/acute myocardial infarction, PCTA/CABG, and stroke were the only others of the 65 extra variables proposed for collection at *'Get Checked'* checks that more than one-third of respondents were willing to collect.

Discussion

This study set out to check that the *'Get Checked'* programme is sustainable for the GPs and practice nurses who have made it work since it started in 2000. There is increasing evidence that the overall effects of *'Get Checked'* are positive for the population of patients with diabetes who participate,[5-7] but this does not mean that individual patients benefit or that the clinicians who monitor the care of these patients are willing to continue making and reporting *'Get Checked'* checks. We found that 83% of respondents commented positively on the programme and 53% commented negatively, suggesting overall clinician support for *'Get Checked'* in these general practices.

In an international context of fundamentally unsustainable health systems,[8] critical appraisal of policies and services will become increasingly important to ensure that health care resources are appropriately matched to care patients need. There is now abundant evidence that primary care improves health outcomes and constrains health care costs[9] but, curiously given its widely accepted importance, the idea of primary care means different things to different people.[10] In New Zealand (and other countries such as the Netherlands and

Canada) primary care is often equated with general practice but general practice values do not necessarily drive the sector. Here, as in other countries, politicians and public health proponents tend to emphasise population-based strategies in their vision of the primary care concept.[11] The conflicting priorities of clinicians and politicians/managers could threaten the viability of programmes such as *'Get Checked'* if they have no obvious benefit to patients, are poorly remunerated, and/or poorly supported managerially.

'Get Checked' seems to escape two of these three threats. Most respondents to this survey agreed that appropriate funding was a positive aspect of the programme. They appreciated funding levels that enabled checks to be provided at no cost to patients and they recognised both obvious and more subtle downstream benefits of programme management. *'Get Checked'* feedback developed by South Link addressed their educational needs and was useful. Although *'Get Checked'* generated more paperwork and there were problems with downstream services (especially retinal screening services), programme administrators are sensitive to these problems and work to develop ways to overcome them.

The outstanding threat to sustainability, from the perspectives of doctors and nurses, was the problem of *'Get Checked'* having no measurable health benefit to many of the individual patients enrolled in the programme, even though from a population perspective there have been significant diabetes management improvements and health benefits are starting to accrue.[6] Individual providers and practices usually see too few patients to experience these effects in a personally compelling way. The challenge then is to demonstrate to providers the practical value of their work. One obvious way to do this is through funded research that produces results that are communicated directly to providers (research to date has not been specifically funded[5-7]). Another solution may be to allow more flexibility in the programme to concentrate services for patients who are most in need and dilute them for other patients. The problem with this solution is that ultimately all patients with diabetes, including healthy patients, benefit from careful attention to their health care.

The main strength of this research is that it was done. It provides a rare critique of a centrally-conceived, population-based approach to care from a general practice perspective and it gives meaningful insights into the experiences of doctors and nurses who deliver *'Get Checked'* care. These frontline personnel readily acknowledged some substantial advantages to their patients and their practices from participation in the programme, but they also highlight problems (including philosophical problems) that might not otherwise have expression. Agencies responsible for planning, funding, and managing such programmes need to be sensitive to this information.

The main weakness of this research is that data were collected from a survey that had a low response rate. This means that the results represent the views of only half of South Link practices. The other half may hold different opinions. However, the qualitative analysis revealed the types of issues with *'Get Checked'* experienced by providers. A greater participation (higher response rate) may have added more issues but would not invalidate the findings we have presented. We caution against generalising these findings to all doctors and nurses who deliver *'Get Checked'*.

We conclude that the doctors and nurses who deliver the *'Get Checked'* programme to patients with diabetes overall view the current programme as sustainable. They enjoy many positive aspects of the programme but highlight some practical and philosophical problems. Appreciation of these issues should guide modifications to *'Get Checked'*.

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Competing interests

None declared.

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