Brief report

A training course for experts in diabetology in primary care

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Abstract

In the Netherlands so-called Diabetes Care Groups organize the primary diabetes care centrally with delegation to different health care providers. A training course for general practitioners who would like to become experts in diabetology in the primary care setting meets the need to guide the quality management processes in these care groups.

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1. Introduction

In the UK about 24,000 excess deaths among people with diabetes could possibly have been prevented simply through better education, treatment and care. Fewer than half of people with diabetes meet the recommended cholesterol level and a significant minority are not even having it measured [1]. When all US adults diagnosed with type 2 diabetes (T2DM) would meet all quality targets, they would experience an increase in quality-adjusted-life-years and a nearly 23 percent reduction in fifteen-year mortality over a thirty-year simulation period [2]. Critical educational needs and gaps related to coordinated care for patients with diabetes as well as the need for quality- and performance-based educational interventions have been identified [3].

Against this background the organization of diabetes care has changed in the Netherlands (700,000 people with T2DM). Since 2006 about 100 Diabetes Care Groups (DCG) coordinate the primary diabetes care. They are legal entities, responsible for both the quality and the financial aspects of the diabetes care of the affiliated primary care physicians. Health insurance companies provide the DCG of a lump sum and request transparency of the process and outcome indicators [4]. Currently, in about 89% of the T2DM patients their lipid levels are measured and about 57% meet the recommended LDL-cholesterol level <2.5 mmol/l (9667 mg/dl) [5]. The above mentioned change in the Dutch organization of diabetes care is likely to have contributed to these results [6].

However, this organization resulted in the need for specialized general practitioners. For this purpose a training course
Table 1 – The seven competences of an expert in diabetology in primary care.

<table>
<thead>
<tr>
<th>Competence</th>
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<tr>
<td>1. Being in the position to treat T2DM patients on an evidence-based manner</td>
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<td>2. Being able to implement guidelines to improve diabetes disease management</td>
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<td>3. Being able to advise colleagues physicians and nurse practitioners with regard to T2DM care</td>
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<td>4. Being able to initiate quality improvement projects in diabetes care</td>
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<td>5. Being able to educate general practitioners and nurse practitioners</td>
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<td>6. Being able to build a regional network of diabetes health care providers</td>
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<tr>
<td>7. Being able to continuously develop the own skills and to keep the knowledge on T2DM updated</td>
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for experts in diabetology started in 2006 under the auspices of the Dutch College of General Practitioners.

Experts in diabetology in the primary care setting could possibly also play a role in for example the Clinical Commission Groups (CCGs) in the United Kingdom and Accountable Care Organizations (ACOs) in the United States and, and perhaps in other primary health care organizations across the world. Because diabetes care is likely to shift from hospital based care to primary care worldwide, we think this model might be applicable for other countries too. Here we describe the aim, skills taught and structure of the course and the experiences of the participants of a training course for experts in diabetology.

2. Aim of the course

The course aims to train general practitioners with special interest in diabetes to become an expert in diabetology with competences to support and improve the quality of diabetes care in the DCGs.

3. Skills taught

Participants have to obtain several competences (Table 1). Basically they should be skilled in treating T2DM patients in an evidence based way. Only with this competence the expert can advise other diabetes care providers and develop diabetes educational programs. So they should also be trained in teaching. Besides they have to develop negotiating skills, because they will have to negotiate with for example health insurance companies. They should be able to continuously develop their own skills and keep their knowledge on diabetes updated.

4. Structure of the course

A two years program is offered with ten plenary meetings and eight meetings in small peer groups. Most teachers are specialist (MD, PhD) working in the academic medical centers in the Netherlands.

Each year a two-day symposium is organized in which specific skills are trained. The study load is one day per week during two years, providing the maximum of CME points annually. The following program is offered to the trainees:

Semester 1:
- The course starts with a ten hours educational program in evidence based medicine. Participants learn to assess scientific articles and to translate scientific information into practical advice for each diabetes professional.
- All aspects of diabetes are lectured, for example the pathophysiology of T2DM and its complications, prevention of T2DM, treatment of hyperglycemia, cardiovascular risk management in T2DM, self-management education, lifestyle aspects.

Semester 2:
- Participants are taught to develop an educational program for the different diabetes professionals and how to perform in educational sessions.
- Participants are offered a program to improve their presentation skills.

Semester 3:
- The trainees have internships of two or three days at outpatient departments, to observe and discuss the work of the endocrinologist, ophthalmologist and podiatrist and to assess the organization of diabetes care.
- Each participant should write a short scientific article.

Semester 4:
- Participants are offered a program to negotiate about the funding and organization of diabetes care.
- Participants learn how to deliver quality indicators, organize benchmark meetings, provide feedback and develop projects to improve diabetes care.

Trainees fill in a digital portfolio with reflections on all activities. Based on the portfolio participants may pass the final judgment by the course staff (HEH and GR).

5. Experiences

In 2012 all 44 participants received a questionnaire to evaluate the course. At that moment two courses had been finished, the third had almost finished. Those who had finished the course were asked for their experiences as an expert. The total response rate was 86.4%.

Participants’ mean age at the start of the course was 47.8 years (31–58); about 70% were man. They had on average 16.3 (5–26) years of experience in patient care and delivered patient care on average 35.7 h (16–55) per week. Six out of ten participants had a function next to their working as a GP. For most participants the DCG paid the costs of the course (8055 GBP/€ 9500). Participants spent 6.9 (2.5–20) h a week to the course.

Seventy percent of the participants passed the two finished courses. Those who did not, mentioned the study load and not matching expectations as main reasons for that. Of the
participants who passed, 96% is functioning as an expert, with an average work load of 6.7 (1–16) h a week. At the end of the course 78.8% of them expected to be well prepared to their responsibilities. Once in function in the DCG this percentage remained stable.

6. Discussion

Because of the new organization of diabetes care in the Netherlands, resulting in the establishing of so-called Diabetes Care Groups, the need for diabetes experts in the primary care field arose. With our course we seem to provide in the possibility to guide the processes in the DCG. The competence profile of the experts matches the needs of the DCG. The DCGs confirm the value of the employment of an expert by facilitating their participation in the course. Currently, about half of all DCGs employ an expert in diabetology. Because diabetes care is likely to shift from hospital based care to primary care worldwide, we think this model might be applicable for other countries too. The WONCA already embedded special interest groups. Perhaps other primary health care organizations across the world, comparable with the Dutch College of General Practitioners, can facilitate the development of similar training courses for general practitioners to facilitate and improve diabetes care in their countries.

Conflict of interest

The authors have no financial or other relationships to disclose as potential conflicts of interest.

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REFERENCES