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ORIGINAL ARTICLE

Professionals' perception of circuits of care for hypertensive or diabetic patients between primary and secondary care☆

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KEYWORDS
Primary care;
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Abstract
Objective: To determine the flow of care for patients with type 2 diabetes mellitus (T2DM) and hypertension between primary care (PC) and specialized care (SC) in clinical practice, and the criteria used for referral and follow-up within the Spanish National Health System (NHS).
Design: A descriptive, cross-sectional, multicenter study.
Placement: A probability convenience sampling stratified by number of physicians participating in each Spanish autonomous community was performed. Nine hundred and ninety-nine physicians were surveyed, of whom 78.1% (n = 780) were primary care physicians (PCPs), while 11.9% (n = 119) and 10.0% (n = 100) respectively were specialists in hypertension and diabetes.
Key measurements: Were conducted using two self administered online surveys.
Results: A majority of PCPs (63.7% and 55.5%) and specialists (79.8% and 45.0%) reported the lack of a protocol to coordinate the primary and specialized settings for both hypertension and T2DM respectively. The most widely used method for communication between specialists was the referral sheet (94.6% in PC and 92.4% in SC).

The main reasons for referral to a specialist were refractory hypertension (80.9%) and suspected secondary hypertension (75.6%) in hypertensive patients, and suspicion of a specific diabetes (71.9%) and pregnancy (71.7%) in T2DM patients.

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Conclusions: Although results showed some common characteristics between PCPs and specialists in disease management procedures, the main finding was a poor coordination between PC and SC.

PALABRAS CLAVE
Atención primaria;
Niveles de atención de salud;
Hipertensión;
Diabetes mellitus tipo 2

Percepción de profesionales sobre los circuitos asistenciales del paciente hipertenso o diabético entre la atención primaria y atención especializada

Resumen
Objetivo: Conocer el flujo de atención entre la atención primaria y la atención especializada (AE), así como los criterios usados para la derivación y posterior seguimiento, en relación con el paciente con hipertensión arterial (HTA) y diabetes mellitus tipo 2 (DM2).
Diseño: Estudio descriptivo, transversal y multicéntrico.
Emplazamiento: Se realizó un muestreo probabilístico, de conveniencia y estratificado por número de médicos en cada CCAA. Participaron 999 médicos, 78,1% (n = 780) especialistas en atención primaria (EAP), 11,9% (n = 119) especialistas en hipertensión y 10,0% (n = 100) especialistas en diabetes.
Mediciones principales: Se emplearon 2 formularios de recogida de datos, autoadministrados vía *online*.
Resultados: El 63,7% y el 55,5% de los EAP y el 79,8% y el 45,0% de la AE declararon la falta de un protocolo de coordinación entre los niveles para el manejo del paciente con HTA y DM2, respectivamente. El método de comunicación más frecuentemente usado entre los niveles asistenciales fue la hoja de derivación (94,6% en EAP y 92,4% en AE). Los principales criterios de derivación al médico de AE del paciente con HTA fueron la hipertensión resistente (80,9%) y la sospecha de hipertensión secundaria (75,6%), siendo la sospecha de DM específica (71,9%) y el embarazo (71,7%) en el paciente con DM2.
Conclusiones: Aunque se observaron coincidencias en algunos aspectos de la práctica clínica habitual entre ambos niveles asistenciales, las discrepancias evidenciadas mostraron una escasa coordinación entre EAP y AE.

Introduction

High blood pressure (HBP) and type 2 diabetes mellitus 2 (T2DM) represent a significant socioeconomic and healthcare burden, and are both risk factors for cardiovascular disease. The prevalence of HBP and T2DM has increased due to the gradual aging of the population. In addition, factors such as obesity, the lack of regular physical activity, and unbalanced diet have contributed to the development of these diseases.[1–3]

The prevalence of HBP in Spain ranges from 15% to 20% in the population aged 15 years or older, and progressively increases to a rate greater than 70% in the population >65 years of age.[4] T2DM accounts for 90% of cases of diabetes, with a prevalence ranging from 10% to 15% in the adult population.[5,6] These diseases represent substantial costs for the Spanish healthcare system. The cost of a hypertensive patient may be up to twofold greater as compared to a normotensive subject, while the annual cost of a patient with T2DM is approximately 37% higher as compared to subjects with no diabetes[7,8]

According to the Spanish Society of Hypertension, 7% of the reasons for consulting primary care physicians (PCPs)[9] are related to HBP, which is the main reason for consultation. T2DM is estimated to be the health problem that generates the most demand and is the most time-consuming, and is responsible for up to 29.1% of all nursing visits in primary care (PC).[10]

The efficient control of these diseases requires the optimum organization of care and an adequate coordination of healthcare services. In Spain, PC is the first point of contact of patients with the healthcare system, and its objective is to achieve continuous, integrated, global, and individualized care. It also serves as the entry point to specialized care (SC).

Although the healthcare system has reached a high degree of development, both in PC and SC, a deficient relationship exists between the care levels. This is mainly due to inadequate resources, the care burden, competence between levels, communication failure, and the incomplete information sometimes transmitted in referral documents.[11]

The deficient coordination of healthcare services has negative consequences such as ineffective resource management, decreased care quality, unnecessary referrals, the loss of the overall patient perspective, and poor disease control.[12–16] All these consequences have a monetary impact, by increasing the cost of treating the disease.