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Perceptions of general practitioners on initiation and intensification of type 2 diabetes injectable therapies. A quantitative study in the United Kingdom

Daniel Sterzi^a, Sébastien Auziere^b, Divina Glah^c, Marie Markert Jensen^{d,*}

^a Kantar Health, Calle de Julian Camarillo, 42, 28037 Madrid, Spain

^b Kantar Health, 3 Avenue Pierre Massé, 75014 Paris, France

^c Novo Nordisk, 3 City Place Beehive Ring Road, Gatwick, West Sussex RH6 0PA, UK

^d Novo Nordisk, Arne Jacobsens Allé 17, 9, 2300 København S, Denmark

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ABSTRACT

Most diabetes care is done by general practitioners (GPs) in the UK. This study aimed to determine GPs' comfort level in initiating and intensifying injectable therapies, identifying any associated barriers, and assessing reasons for referral to specialists. This web-interview included 128 general practitioners (GPs) experienced in type 2 diabetes (T2D) management, as well as 57 specialists and 30 nurses who were studied for secondary objectives. GPs felt more comfortable initiating the 1st injectable therapy – typically the glucagon-like peptide-1 receptor agonists (GLP-1 RA) – than the 2nd. The main barriers to initiating injectables were related to the complexity of injectable therapies and the lack of comfort with complex patient profiles, namely patients with difficulty achieving glycaemic control or those with significant comorbidities who GPs would rather refer to specialists. The main attributes that would increase their comfort level with initiation of injectables are improved glycaemic control, weight control and low risk of hypoglycaemia. An injectable therapy with these attributes could help to overcome barriers to initiating injectable therapies among GPs other healthcare professionals in primary care.

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1. Introduction

Most diabetes management is undertaken by primary care providers: only 20% of people with diabetes ever see an

endocrinologist [1]. However, the increasing complexity of diabetes management drives primary care providers (PCPs) to refer patients to specialists, or to maintain patients at suboptimal glycaemic levels. Many patients with type 2 diabetes (T2D)

* Corresponding author at: HEOR Insulin, Global Market Access, Novo Nordisk A/S, Vandtårnsvej 114, DK-2860 Søborg, Denmark.

E-mail address: mmtj@novonordisk.com (M. Markert Jensen).

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are not intensified in a timely manner: UK general practice data showed that three years after basal insulin initiation, only 29% of patients have glycated haemoglobin (HbA1c) levels $\leq 7\%$ [2], and 60% of T2D patients are maintained on basal insulin and oral anti-diabetic (OAD) treatments, despite evidence of poor glycaemic control [3].

This study aimed to determine GPs' comfort level in initiating and intensifying injectable therapies. This included the identification of any potential barriers they may face with initiation or intensification, as well as drivers for referral to specialists.

2. Methods

2.1. Study design

This was a national, computer-assisted web interview to assess the perceptions of GPs on injectable T2D therapy. The leading objective was to determine GPs' comfort levels and identify any potential barriers in initiating and intensifying injectable therapy, as well as what drives referral to specialists. Specialists and nurses' perceptions of injectable initiation and intensification in primary care were also explored as a secondary objective assigned to the study.

The study was approved by a European Ethics committee. No patients' data were collected; therefore no informed consent was necessary. The study was conducted in the UK from November 2014 to January 2015.

2.2. Selection of participants

Participants were contacted through a medical physicians' panel (SERMO). They were selected based on: number of years in practice, their role in the management of T2D, time spent in primary care, proportion of time spent with the patient during a consultation, number of T2D patients seen/treated in a month, and number of T2D patients treated with insulin in a month (Table 1). These selection criteria aimed to capture the view of physicians who are experienced in the management of T2D. Physicians meeting selection criteria underwent a 25 min online interview.

2.3. Information collected

Participants answered questions that covered the following topics: comfort level in treating T2D patients and initiating/intensifying injectable therapy, reasons for initiating injectable therapies, attributes that would increase the comfort level, frequency and reasons for referrals to specialists for initiating/intensifying injectable therapies, specialty to which the patient is referred, attributes of an "ideal" injectable therapy and drivers for the referral to specialists. Initiation of a 1st injectable therapy was defined as initiating a glucagon-like peptide-1 receptor agonist (GLP-1 RA) or basal insulin with patients currently treated with OAD. Intensification with a 2nd injectable was defined as adding a basal insulin with patients currently treated with a GLP-1 RA (\pm OADs), or adding either a GLP-1 RA or a bolus insulin in patients currently treated with basal insulin (\pm OADs).

2.4. Statistical analysis

Descriptive statistics (means, standard deviations, median, min and max values) were provided for continuous variables such as age, and number of years of practice or number of T2D patients seen per month. Categorical variables such as gender, dichotomous questions or open-ended questions were summarised as frequencies and percentages when applicable. Confidence intervals were also provided to ensure precision of range of values reported.

Missing values were not replaced. Comparisons used z-test, Chi²-test or analysis of variance, as appropriate. P-value for all tests was set at a significance level of 0.05.

In assessing the drivers to refer a T2D patient to a specialist for initiation of an injectable therapy, GPs were asked to assess a set of attributes that could influence their decision. Data were analysed using a Maximum Difference Scaling technique [4]. This technique allows to best discriminate and evaluate a large number of attributes to reveal which amongst them would be the most influential and which would be the least influential. The exercise consisted of seven scenarios, each scenario showing a group of three attributes appearing on a screen at once. The attributes shown for each scenario were determined by an experimental design. In each scenario, GPs were asked to select the attribute they believed was the "most important/influential" in their decision to refer a T2D patient to a specialist and then the "least important/influential". Separate questions were asked for the 1st and 2nd injectable. Results are expressed in "winning percentages" [4]: the modelled percentage of time an attribute is chosen as the "most important/influential" vs. other attributes based on the experimental design.

3. Results

3.1. Characteristics of participants and current practice

After screening, 128 GPs were selected to participate. Their mean age (SD) was 45 years (8.4), with 17.26 (7.2) years in practice. Details on the current practice of participants are summarised in Table 1.

Specialists involved in the study managed a higher number of patients treated with injectable therapies, and initiated injectable therapy more frequently than GPs. In a typical month, less than one quarter of T2D patients requiring an injectable therapy were referred to specialists. GPs and specialists agreed on HbA1c levels at which patients needed intensification. This is observed amongst specific patient subgroups, such as obese patients, patients with renal impairment or significant comorbidities, patients older than 65 years old and patients in need of 3rd party assistance (Fig. 1). No significance difference was observed between GPs' and specialists' perceptions.

3.2. Comfort level of initiating or intensifying with injectable therapies among GPs

Table 2 summarises the comfort level of GPs in initiating an injectable therapy. GPs felt more comfortable initiating the

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