RESEARCH LETTER

Organization of diabetes primary care: a review of interventions that delegate general practitioner tasks to a nurse

Andrea S Fokkens MSc,1 P Auke Wiegersma MD PhD2 and Sijmen A Reijneveld MD PhD3

1PhD Student, 2Senior lecturer Public Health, 3Professor of Public Health, Department of Health Sciences, University of Groningen, University Medical Center Groningen, the Netherlands

Correspondence
Ms Andrea Fokkens
Department of Health Sciences
University of Groningen
University Medical Center Groningen
Ant. Deusinglaan 1
9713 AV Groningen
the Netherlands
E-mail: a.s.fokkens@med.umcg.nl

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To the editor

The multifaceted and complex nature of diabetes care makes good organization of diabetes care within primary care important [1–3]. This has led to new health care models. One potentially promising approach to developing new models in diabetes care is the use of multidisciplinary cooperation [4]. A multidisciplinary team of primary care professionals – general practitioner (GP), practice nurse, diabetes specialist nurse and dietician – may well satisfy the high demands of diabetes care. In this kind of cooperation tasks can be delegated from one type of health professional to another, for instance from doctor to nurse [4,5]. Care models may be promising but the effects of task delegation to a nurse in diabetes primary care are still unclear. The aim of this study was to summarize the evidence as regards the effects of task delegation from GP to nurses in diabetes primary care.

Methods

Identification of studies

A literature search was performed for studies published between 1990 and December 2008 in Medline and Cinahl (Cumulative Index of Nursing and Allied Health Literature). The keywords used were ‘Diabetes Mellitus’ in combination with ‘integrated care’, ‘shared care’, ‘delegation, professional’, ‘nurse’, ‘nurse’s role’, ‘multidisciplinary care’, ‘patient care team’ and ‘physician–nurse relation’. The studies had to meet the following inclusion criteria: to use a sample of adult patients with diabetes type 2; provide an evaluation of an intervention involving the delegation of GP tasks to a nurse; have a follow-up of at least 6 months, and be published in a peer-reviewed journal. Studies were excluded if the nurse only provided a short intensive programme or was restricted to educating health care professionals. These where not considered to be full delegations of task. We included randomized controlled trials and other comparative study designs such as non-randomized trials, and before–after comparisons.

Quality assessment

To rate the quality of the selected studies we used a checklist developed by Downs and Black, intended for use in both randomized and non-randomized studies [6]. A maximum total score of 32 could be achieved. Studies with a score less than or equal to 16 were considered to be of low quality.

Reporting and analysing

We compared the following parameters: glycosylated haemoglobin (HbA1c), blood pressure and lipid values. These clinical outcomes are important for the management of diabetes [7–9]. A difference was considered statistically significant if \( P < 0.05 \).

Results

Study selection

The literature search resulted in 1133 publications from Medline and an additional 206 studies from Cinahl. Of these publications 204 (172 Medline, 32 Cinahl) required further assessment. In the second stage, another 194 articles were excluded. The reasons for
### Table 1 Characteristics of the studies included on task delegation from GPs to nurses

<table>
<thead>
<tr>
<th>Author</th>
<th>Setting</th>
<th>Sample size</th>
<th>Design</th>
<th>Comparison I and C with change from baseline</th>
<th>Quality score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aubert [10]</td>
<td>2 primary care clinics</td>
<td>Nurse case manager</td>
<td>RCT</td>
<td>71 (83% type 2)</td>
<td>21</td>
</tr>
<tr>
<td>Forbes [12]</td>
<td>4 nurse-GP pairs</td>
<td>District nurse</td>
<td>PP pilot project</td>
<td>12 – NA</td>
<td>11</td>
</tr>
<tr>
<td>Gabbay [13]</td>
<td>2 primary care clinics</td>
<td>Nurse case manager</td>
<td>RCT</td>
<td>150 182</td>
<td>19</td>
</tr>
<tr>
<td>Groeneveld [14]</td>
<td>15 general practices</td>
<td>DSN, dietician</td>
<td>RCT</td>
<td>84 140</td>
<td>20</td>
</tr>
<tr>
<td>Lenz [15]</td>
<td>7 NP</td>
<td>NP</td>
<td>RCT</td>
<td>23 24</td>
<td>17</td>
</tr>
<tr>
<td>Ovhed [16]</td>
<td>2 primary care centres</td>
<td>Practice nurse specially trained in diabetes care</td>
<td>POS</td>
<td>152 242</td>
<td>15</td>
</tr>
<tr>
<td>Peters [17]</td>
<td>1 medical centre</td>
<td>Nurses</td>
<td>POS</td>
<td>97 (90.7% type 2)</td>
<td>15</td>
</tr>
<tr>
<td>Vrijhoef [19]</td>
<td>11 GP</td>
<td>DSN</td>
<td>PP*</td>
<td>175 –</td>
<td>18</td>
</tr>
</tbody>
</table>

*Additional comparisons with a simultaneous beginning study on outpatient care where made, data not shown.*

C, control; DSN, diabetes specialized nurse; GP, general practitioner; I, intervention; NP, nurse practitioner; PCP, primary care provider; PN, practice nurse; POS, prospective observational study; PP, pre-test post-test design; RCT, randomized controlled trial.
Table 2: Outcomes of the studies included on the task delegation from GPs to nurses

<table>
<thead>
<tr>
<th>Author</th>
<th>HbA1c (%)</th>
<th>Blood pressure (mmHg)</th>
<th>Cholesterol (mmol L⁻¹)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intervention</td>
<td>Follow-up</td>
<td>Control</td>
</tr>
<tr>
<td></td>
<td>Baseline</td>
<td></td>
<td>Baseline</td>
</tr>
<tr>
<td>Aubert</td>
<td>9.0 (-)</td>
<td>7.3 (+)</td>
<td>8.9 (-)</td>
</tr>
<tr>
<td>Cleveringa</td>
<td>7.0 (0.9)‡‡</td>
<td>6.8 (0.9)‡‡</td>
<td>–</td>
</tr>
<tr>
<td>Forbes</td>
<td>6.1 (1.3)</td>
<td>7.1 (1.4)</td>
<td>–</td>
</tr>
<tr>
<td>Gabbay</td>
<td>7.4 (1.5)</td>
<td>7.45 (1.4)</td>
<td>7.36 (1.4)</td>
</tr>
<tr>
<td>Groeneveld</td>
<td>–</td>
<td>7.1 (1.2)</td>
<td>–</td>
</tr>
<tr>
<td>Lenz</td>
<td>–</td>
<td>8.9 (2.8)</td>
<td>–</td>
</tr>
<tr>
<td>Ovhed</td>
<td>–</td>
<td>6.9 (1.6)‡</td>
<td>–</td>
</tr>
<tr>
<td>Peters</td>
<td>11.9 (-)³</td>
<td>8.8 (-)³</td>
<td>10.0 (-)³</td>
</tr>
<tr>
<td>Ubink-Veltmaat A</td>
<td>7.5 (-)³</td>
<td>–</td>
<td>10.0 (-)³</td>
</tr>
<tr>
<td></td>
<td>B: 7.3 (-)³</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Vrijhoef</td>
<td>8.0 (1.5)‡</td>
<td>7.7 (1.3)‡</td>
<td>–</td>
</tr>
</tbody>
</table>

Values are means ± standard deviations unless mentioned otherwise.

* Other outcome measurement: % patients who achieved target values.

1 Value is median.

2 Significant difference between intervention and control with respect to change from baseline.

3 Significant difference between intervention and control.

4 Single test for statistical differences between intervention A and B, and the control group.

5 Due to less frequent recording at the control group no statistical comparison possible.

6 Significant difference between baseline and follow-up.

-, value is not measured/given; DBP, diastolic blood pressure; HbA1c, glycosylated haemoglobin; LDL, LDL cholesterol; SBP, systolic blood pressure; TC, total cholesterol.
exclusion were: the intervention did not meet the inclusion criteria (160); the study population did not meet inclusion criteria (29); the article, including the abstract was in a non-European language (2); and the articles reported results that duplicated contents of another publication (3). A full reference list of excluded studies is available from the authors. In the end, 10 studies satisfied our inclusion criteria (Table 1) [10–19]. Table 1 shows the characteristics of the included studies.

**Study characteristics and quality assessment**

The activities of the nurse could be divided into three distinct categories being: main care provider, only performing quarterly controls, or only carrying out the annual examination (Table 1). Only one study reported referrals between nurses, i.e. from a nurse case manager to a diabetes nurse educator [13]. Table 1 also shows the results of the quality assessment of the 10 included studies.

**Results of the studies reviewed**

Due to the large differences between the studies, both in design and statistical methods, it was not possible to perform pooled analyses. Of the 10 studies, seven showed a significant positive effect in one or more clinical outcome (Table 2). Four studies reported a change in the proportion of patients that reached the target values set in these studies [11,13,18,19]. In the study by Ubink-Veltmaat, the proportion of patients with a blood pressure less than or equal to 150/85 mmHg increased from 40% to 52% (P < 0.001) in intervention group A (extensive nurse support), and remained stable in intervention group B (limited nurse support) and the control group [18]. In the same study the percentage of patients with HbA1c less than 7.0% remained stable in both intervention groups, and decreased from 50% to 42% in the control group (P < 0.05). Vrijhoef et al. found a decrease in the proportion of patients with an HbA1c greater than 8.5%, from 26.6% at baseline to 20.3% at follow-up [19]. In the study by Gabby et al., the percentage of patients in the intervention group with a blood pressure lower than 130/80 mmHg increased from 29% at baseline to 49% at the conclusion of the study [13]. Finally, Cleveringa et al. found, after 1 year, a significant increase in the percentage of patients with a HbA1c lower than 7.0% (from 61% to 67%, P < 0.001), blood pressure lower than 150/85 mmHg (from 49% to 62%, P < 0.001) and total cholesterol lower than 5.0 mol L⁻¹ (from 47% to 63%, P < 0.001). After excluding lower quality studies [12,16,17], five out of the resulting seven studies showed a significant positive effect in one or more indices of clinical outcome. Thus, even after exclusion of the three lower quality studies the overall effect of the different interventions remains the same.

**Discussion**

This review yielded 10 intervention studies that studied delegation of GP tasks to a nurse working in diabetes primary care. Due to the heterogeneity of the studies and incomplete reporting of study outcomes, it was not possible to calculate an overall effect. However, none of the studies found a statistically significant negative effect for any of the clinical outcomes, that is, HbA1c, blood pressure and cholesterol. Seven studies found a statistically significant positive effect regarding these clinical outcomes. The majority of studies included in this review scored relatively low on the quality score list. This was mainly due to the design not being randomized, not being a blinded study and/or an insufficient number of participants. We also found that only four studies made comparisons with respect to changes from the baseline. Our findings indicate that interventions in which the nurse fulfills the role of the primary care provider results in larger effects on clinical outcomes than interventions where the nurse fulfills a smaller role. No major improvements in glucose control were found in the studies where the role of the nurse was limited to an annual review (with on-demand consultation possibilities). However, small sample sizes and an already good HbA1c at baseline require caution in drawing conclusions about the effect of the specific role of the nurse. Findings regarding the effect of the various nurses’ roles remain inconclusive, as well as the effect of sharing tasks between nurses. The statistical significant effects on clinical outcomes found were all in favour of task delegation. Further research is necessary to determine other possible effects of the delegation of task, such as cost reduction, reduced workload for GPs, more education/information, and satisfaction of patients and health care professionals. Because of the methodological weaknesses of the available evidence, our conclusions will require confirmation in further studies. Moreover, the effect of the different roles of nurses remains unclear, making it virtually impossible to make evidence-based recommendations. Current evidence, however, appears to indicate that the delegation of GP tasks to a nurse in diabetes primary care is at the very least a promising option with respect to improving patient care. We contribute this Research Letter to the Journal of Evaluation in Clinical Practice as a call for research on the (cost) effectiveness of nurse delegation in diabetes care in particular and in health services in general.

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**References**


