



Service Priorities and Programmes Electronic Presentations

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A Model of Structured and Equitable Care for Patients with Diabetes across the Disease Continuum in KEC

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Introduction

Introduction: Good collaboration between multidisciplinary health care professionals and patients is the key to success in diabetes management. Metabolic Risk Assessment and Management (MRAM) programme was developed in KEC in 2014 to provide a structured clinical pathway for patients with diabetes. The programme aimed to facilitate risk stratification and treatment intensification through periodic comprehensive assessment and individualized care plan formulation.

Objectives

Objectives: 1. Provide periodic structured and equitable care for patients with diabetes in KEC 2. Allow formulation of care plans, empowerment and treatment intensification for patients with different disease complexities

Methodology

Methodology: All diabetic patients newly presenting to KEC and diabetic patients already under our care who are below age 75 and had no retinal screening in the preceding 3 years were identified from CDARDS and offered: (1) Comprehensive metabolic assessment (2) Empowerment and treatment intensification program (3) Referral to Endocrinologists/ Ophthalmology/ Dietetic/ Podiatry services according to predefined criteria where necessary

Result

Results: 4,050 patients underwent MRAM during 1st January to 31st December 2015, with mean age of 59.97 ± 13.04 years old and female to male ratio of 1 : 1.35. Mean HbA1c, significantly improved from $7.61 \pm 1.61\%$ (upon MRAM) to $7.46 \pm 1.49\%$ (latest results) with $p = 0.000$. The proportion of patients with HbA1c < 7% increased by 3.5% (from 41.2% to 44.7%); while the patients with HbA1c > 10% decreased by 2.2% (from 8.9% to 6.7%). Referrals were made to podiatrists (9%), dietitians (7.5%), ophthalmologists (15%) and Endocrinologist (4.4%). 5.2% patients received

empowerment and intensification by diabetes nurses, while 26.7% were under joint care by endocrinologists. The KEC MRAM program with unified care plans and referral criteria was an effective and useful model of structured clinical pathway patients with diabetes across the disease continuum.