Editor’s Note

Diabetes in Primary Care: Back to Basics

Diabetes care delivery has transformed in many ways during the past few decades yet continues to remain a major healthcare challenge. Despite robust evidence linking optimal diabetes management with improved clinical outcomes, a care gap still persists between day-to-day clinical practice and evidence-based guidelines (1). More than 80% of the care for individuals with diabetes is provided within the primary care setting (2); therefore, the recently published 2013 clinical practice guidelines emphasized the organization of diabetes care by incorporating the Chronic Care Model (CCM) in the primary care setting utilizing as many elements of CCM as possible (3). The current issue of the Canadian Journal of Diabetes highlights several key aspects of diabetes care delivery in primary care.

Greiver et al (4) analyzed a convenience sample of 272 469 patients from a national primary care electronic medical record database and reported a significantly higher rate of primary care utilization and comorbidities in patients with diabetes than in those without and reported a higher than previously reported estimated population prevalence of diabetes of 7.6%.

Several clinical care models for diabetes care exist in Canada. Kiran et al (5) analyzed the Ontario administrative healthcare data of 757 928 individuals with diabetes between 2006 and 2008 based on 3 predefined outcomes: testing of hemoglobin A1C, testing of and retinal examination. Those enrolled in either non-team or team-based blended capitation model care were more likely to receive optimal tests than those enrolled in a blended fee-for-service model, whereas those who were assigned to a traditional fee-for-service physician and who were not enrolled to any model were least likely to receive optimal monitoring. However, it is rather worrisome that overall only 27% of all individuals with diabetes received the optimal number of all 3 recommended tests. Reichert et al (6) have reported an innovative diabetes care delivery model for vulnerable people with diabetes, such as those with multimorbidities, with complex social issues and without family physicians. The program incorporates an expanded care team that includes primary care physicians, nurse practitioners, social workers and certified diabetes educators. The program has demonstrated meaningful success with significant improvement in glycemic control as well as other comorbidities.

A key element to success in diabetes care delivery would be to target appropriate individuals and develop specifically tailored programs for various populations. Hwee et al (7) have reported an interesting trend of overuse of diabetes services in some areas. Using the population health administrative database of Ontario, the authors have reported that almost 17% of individuals attending the diabetes education centres did not, in fact, have diagnosed diabetes. The trend was higher in centres based in community health centres or First Nations than in those based in hospitals. It is likely that most of these individual had pre-diabetes; however, as noted by the authors, most centres lack programs to deliver education for diabetes prevention.

These studies suggest that important policy decisions will be required to channel healthcare funding into programs with demonstrable success and avoid over- and underutilization of such programs.

Evidence-based decision support systems are an integral part of the diabetes care strategy. Novel strategies looking at developing and incorporating computerized decision support algorithms in various aspects of diabetes care delivery ought to be explored. In this issue, Abidi et al (8) have reported a novel research methodology employing behavioural-change models to develop and evaluate web-based decision-support systems for both primary care physicians and patients, based on the 2013 clinical practice guidelines, so as to evaluate and promote adherence to disease self-management programs. Such programs will have long-term implications for CCM-based models in diabetes care delivery.

In summary, diabetes care in the primary healthcare setting is a dynamic and complex entity that involves multiple stakeholders. Several care delivery models are being used across Canada. It is conceivable that eventually, broader determinants of their relative success will enable a more cohesive national strategy, which is imperative, given the scope of the problem and the limitations of healthcare expenditures.

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References

