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Diabetes Care with a Difference: The London Primary Care Diabetes Support Program

It looks like an ordinary house on a semi-residential street in London, Ontario. Only when you see the sign do you realize that this is no ordinary residence, but a family medical centre — the St. Joseph’s Family Medical Centre and home to the Primary Care Diabetes Support Program; a model respected by patients and professionals alike for its success in preventing and managing diabetes at the primary care level and reducing the need for acute interventions.

It’s an innovative model that focuses on continuity of patient care. It addresses socio-economic factors in each care plan and uses group and one-on-one diabetes self-care support. The model also stresses outreach to marginalized patients including those with no family physician and those who are unable to effectively navigate the health care system due to mental illness, health literacy etc. All this is delivered with a wellness orientation rather than an illness orientation by an interprofessional team of health care providers.

At St Joseph’s Health Care, London’s Primary Care Diabetes Support Program, the team includes a physician, a nurse practitioner/clinical nurse specialist, a registered nurse/certified diabetes educator and a Registered Dietitian. They have been pioneering interprofessional primary care for diabetes for the past 13 years — first at a local Community Health Centre and now within a Family Practice Unit under the umbrella of St Joseph’s Health Care.

A patient’s first appointment here is with the Nurse Practitioner and includes an intake assessment that goes beyond the usual dimensions of health to include a comprehensive assessment of the broader determinants of health so critical to effective chronic disease prevention and management including food security, social supports, employment security, housing and the like.

The London team believes patients get lost because of a broken link between the health system and
community resources. The team works hard to create community connections and to consider patient needs regardless of existing limitations in the system. They address the social determinants of health through community and social service partnerships and a focus on seamless access to the full continuum of diabetes care.

Physician lead, Dr. Stewart Harris, explains that there are major gaps in the traditional diabetes care continuum. Effective diabetes management requires that patients have access to an ongoing source of self-care support, which is critical to enable them to effectively manage their disease and prevent its devastating complications.

“Nobody picks up the ball to support the patient, and to support the process for getting the patient to target,” says Dr. Harris.

In London, they do it differently. All patients are monitored regularly either in person, by telephone or electronically until their blood sugar stabilizes. The care team does 20-30% of patient support related to follow up using distance technology, saving the patient on lost time from work, transportation and child care. Patients can email or call at any time with questions. Telephone tag is used to advantage; patients can leave the details of their recent sugar levels and their insulin use. Health care providers then prescribe insulin adjustments by phone or email.

The continuity of care often means dramatic changes for patients. Travis is a Type-1 diabetes patient. He was referred to the London program after many hospital admissions. When he first arrived, he was close to having a limb amputated and was on the wrong insulin. The London team stabilized his blood sugar levels with different medications, helped find him a family doctor, enrolled him in group education sessions and assisted him in making self-management plans. He also drops into the Clinic for regular monitoring.

“I couldn’t control my sugar levels at all,” Travis says. “I was at a point where nothing was working for me, in and out of the hospital two or three times a year, I couldn’t get it together… it was just craziness.”

Now his diabetes is under control.

“I have felt the best that I have in a long, long time. I mean, a long time.”

Outreach, particularly to vulnerable populations, is a cornerstone of the London approach. An estimated 40,000 patients are without family doctors in the London area and of those an estimated 9% have Type 2 diabetes and are offered services at the London clinic. London is one of five receiving centres for Government Sponsored Refugees and 40-60% of the London Clinic patients at any given time are members of these newcomer populations. Nearly half of the population served in this new clinic are not fluent in English; close to a third have no drug plan and over 85% are struggling with poverty.
Nurse Practitioner / Clinical Nurse Specialist Betty Harvey and Dr. Stewart Harris actively connect to the social service and nonprofit sectors, serving homeless people, the mentally ill, and refugees. Betty’s career in nursing and her commitment to serving multicultural communities was inspired by her background working in refugee camps and growing up in Africa. Dr. Harris has worked overseas, mostly with the World Health Organization. Creating a program with cultural and linguistic sensitivity was important to both of them.

Once at the clinic, as they did with Travis, the London team helps new patients find a family doctor and connect to social or disability assistance or the community social services they need. Creating links with community health teams and mental health services is part of their mandate.

One of the patients benefiting from this approach is Colombia-born Hernan. When he was referred to the Primary Care Diabetes Support Program by a hospital, he was an unattached patient, but poor health and lack of a family doctor were the least of his problems. Economic obstacles were not just working against his good health, they were determining his health. With poor English, Hernan and his wife were unable to cope with all the paperwork to access government assistance. They had no income, no government financial assistance, no way of paying for food, housing, transportation or medication. The economic stress was crippling.

In group sessions with other diabetes patients and in one-on-one sessions with health care providers, Hernan felt that he could talk about the struggles which had significant effect on his diabetes. Though his emotional and financial obstacles were not in the traditional scope of medical practice, they were addressed by Dr. Harris and the team, by helping him navigate through the social service system and by advocating on a political level as well. For example, community recreation services were not accessible to Hernan and many of their other patients. Registration for community centres and activity programs requires a credit card and a permanent address – things that patients struggling with illness or poverty can’t always provide. The London team took the issue to City Hall and managed to change the system, so that there were no longer barriers preventing access to activity programs to facilitate good health.

Teamwork, continuity of care, electronic monitoring, advocacy; all are key elements in setting the London Primary Care Diabetes Support Program apart. Continuous quality improvement is another. The team is rigorous in their commitment to evidence-based practice.

While it may at first appear daunting, what they’ve learned in London is that quality improvement does not have to be a massive, experts-only initiative. After just three months of operation, they began evaluating how well they were treating to guidelines and how well their patients were doing.
“It doesn’t have to be all your patients. If you take 50 people, and look at them, you’ve learned something. Do something small, then check, and if it doesn’t work, try something different.”

But here in London, the approach is working. For example, six months after the introduction of this diabetes program, the number of patients whose LDL cholesterol was at target jumped by 13%, and the number whose A1C was at target jumped by more than 71%. With unattached patients, the successes were most dramatic — a 65% increase in the number of patients reaching the clinical guideline target for LDL cholesterol and a 50% increase in the numbers of patients reaching their targets for blood pressure.

This small team at the London Primary Care Diabetes Support Program believes that health care reform in their community can start with them, but they want the model to be replicated elsewhere. They believe incubation, through a mentorship period at their centre, is necessary to support other communities implement the model. The staff is now seeking funding to develop a training program for other family health care teams in Ontario.

London’s Primary Care Diabetes Support Program is a win for professionals and patients alike. The team nods in agreement when Amanda Mikalachki, RN and Certified Diabetes Educator at the London Program, says they have very high job satisfaction.

“You just feel such a sense of autonomy. It’s very satisfying work. I will sometimes work very long days, and genuinely I never feel ‘oh, I can’t wait to get out’. You’re tired, sure. But as cliché as it sounds, you feel like you’re making a difference… and it’s great.”

Hernan, too, is full of superlatives. “They are wonderful people,” Hernan grasps for English words. “The attention here is … only medical attention? No. Human attention.”

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For more information about the London Primary Care Diabetes Support Program, contact Betty Harvey, Program Coordinator: 519-646-6000 ext 67270; bharvey6@uwo.ca