ELIMINATING DISPARITIES IN CARE

Case Study: Filipino and Vietnamese Populations Manage Their Diabetes

Goal: To provide diabetes management – including improving HbA1C and blood pressure rates, as well as lipid parameters and health behaviors – for low income, underserved, ethnic populations by removing cultural and language barriers to care.

Demonstrable outcome:
In addition to helping targeted diabetes patients manage their disease, Project Dulce reduced hospital costs by an average of 60 percent by helping patients stay out of hospital emergency departments and inpatient settings.

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Organization: Project Dulce

Location: San Diego, CA

Summary:
Project Dulce began as a pilot project in 1997 and was the result of Community Health Improvement Partners – a broad health collaborative involving hospitals, health centers, health agencies, community based advocacy groups, and many others. The collaborative spearheaded a community needs assessment that identified diabetes as a major health issue for the area. A subgroup within the collaborative developed a peer-education, diabetes management model that became Project Dulce.

With early involvement and ongoing support of the collaborative, all parties had a stake in seeing Project Dulce succeed. Its pilot program was quickly recognized as a model practice and San Diego County became the first to reimburse it for the services provided to county patients. Working with clinics across the area, Project Dulce is now reimbursed by multiple payers.

Q&A:

1. When did Project Dulce begin and what was the origin of its creation?

Started in 1997, Project Dulce was the result of collaboration among health care and community-based organizations in San Diego County. These organizations conducted a community health needs assessment and identified diabetes as an unmet health care need in the community. After completion of a pilot phase, San Diego County adopted Project Dulce as the model of care for medically indigent adult population. A reimbursement structure was designed for the project, which allowed it to expand to community health centers caring for this population throughout the county.

2. How did Project Dulce identify the ethnic populations with which it works

Project Dulce is closely tied to community health centers, which serve as the safety net for San Diego County. The population is primarily Latino with a few health centers serving African American, Filipino, and Vietnamese communities. While the pilot program focused on the Latino community, it made sense to adapt Project Dulce and effectively address diabetes management challenges among various populations.

There was an extensive process to tailor Project Dulce's curriculum appropriately. Focus groups and key informant surveys were conducted to better understand important characteristics of each group, such as:

- Beliefs about diabetes
- Common foods and remedies
- Where people get information
- Who they trust and don't trust

The research was helpful and necessary. An example of what was learned: with the Latino community, a first class involved sharing personal experiences. That format had to be changed for the Vietnamese class, which was less comfortable sharing personal experiences so early in the process.

As a result of the research, the curriculum was changed for each group of Project Dulce's trained peer educators. In addition, all documents were translated and handouts are now available in 12 languages.

3. How does Project Dulce identify and measure potential disparities in care (i.e. clinical data outcomes, community health surveys, etc.)?

Clinical outcome measurement has been a strong emphasis from the beginning. All along, key clinical indicators have been collected, including lipids, blood pressure, weight, complications, and demographic data.

Project Dulce looks at disparities in a variety of ways. Initially, it compared data in all clinics as a whole, comparing clinical outcomes of patients involved in Project Dulce with those who were not involved. There was significant variation in outcome measures among those enrolled in Project Dulce versus those not enrolled. Variations included Project Dulce patients with higher rates of compliance to a diabetes management plan and better health indicators.

Next, Project Dulce looked at the entire county population using health indicators to identify who was not getting proper diabetes diagnosis or management. After identifying these individuals, Project Dulce reached out to them and worked to involve them in the program.

4. How does Project Dulce capture data?

When the program began, Project Dulce used a publicly available diabetes electronic measuring system. Over the years, that system has been adapted and added to in order to accommodate different capabilities. While not an electronic medical record, it is now a stand-alone, electronic database. When a nurse sees a patient, updated information is input directly into the system. The database also enables Project Dulce to get reports and follow-up notes close to real-time.

5. Are there aspects of the program that could be replicated by other health care organizations?

Hospitals often deal with large, uninsured populations who come into the emergency department with diabetes. Many times, these patients don't know they have diabetes and they don't have access to preventive care. They come in again and again, sometimes requiring admission. This can be a huge drain on hospital resources. This care that hospitals are providing is typically not reimbursed.

Project Dulce has compared clinical outcomes and cost variations finding that, in addition to improving health outcomes for these patients, the program saved hospitals an average of 60 percent on costs previously racked up in the emergency department and inpatient setting.

Having an inpatient diabetes coordinator or nurse to check Emergency Department discharge notes, identify patients in need of diabetes management help, and connect those patients with a medical home is a position that pays for itself.

6. What role do interventions play with the caregivers and patients? How are interventions implemented?

Project Dulce takes a very proactive approach to involving patients in their diabetes care. With systems in place to identify uninsured patients with diabetes when they're admitted to the hospital or are discharged from the emergency department, patients are proactively called or visited. The goal is to connect them with a medical home and begin educating them about living with and managing their diabetes.

7. How are quality outcomes assessed?

Project Dulce uses measurements for quality improvement from very basic comparison to more specific analysis.

Monthly, the program runs a list of patients with labs out of range to flag for follow-up by nurses. More specifically, the data are compared using health indicators such as retinal exams. How many patients had exams on their last visit? How does that number compare with Project Dulce patients who had exams? Consistently, there is a large discrepancy.

Similarly, how many patients have A1C over 9? After combing data, those patients are given to a nurse team who proactively contacts each one to get them in and make sure they're getting appropriate management.

Recently, the county added quality indicator measures to Project Dulce's contract. Every month they check those indicators to ensure they are being met.

8. What was the initial cost of the program? Was it grant funded? How is the program currently funded?

As a pilot program, Project Dulce was fully funded but now there is very little grant support. Instead, Project Dulce sustains itself working as subcontractors. The clinics that subcontract with Project Dulce are able to generate revenue for the services Project Dulce provides and pass that payment back to Project Dulce.

After completion of the pilot program and the resulting phenomenal data collected, San Diego County agreed to reimburse Project Dulce for the service they provided to county patients. Overtime, Project Dulce has negotiated contracts with all integral players. This would not have happened without data to demonstrate the successful outcomes of the program.

9. What challenges or obstacles had to be overcome?

An early challenge was the program's rapid growth. After the successful pilot program, Project Dulce grew from one team to four and from a staff of five to 30. It was very challenging to quickly bring a much larger team to the same competency level as the initial team.

Another challenge is ongoing: successful collaboration with primary care and hospital sites. As subcontracted providers, it's essential that Project Dulce be seen as a helpful resource, not an additional "to do" or paperwork requirement for already busy sites. Developing relationships with physicians, nurses, clinical managers, and others while helping busy staff do what needs to be done, rather than focusing solely on achieving Project Dulce's objectives, has gone a long way in building collaboration.

10. What advice would you give others wanting to improve care in similar ways?

There's no cookie cutter model. Successful programs adapt to the populations they serve; therefore, they're all going to look different.

To begin, take a hard look at the data and know what it's costing a hospital to be without a program similar to Project Dulce's. Then, identify key drivers for stakeholders: What does a hospital need to see out of a program like this? What does a primary care site need to see? While the goal is always to make people healthy, it is essential that you flesh out the other arguments. In today's economy, you'll need it.

Project Dulce is a good example of how you can improve health, decrease disparities, and meet financial goals. It takes a lot of work to get there and there will be multiple issues with reimbursement. One of the most important things Project Dulce did was involving everyone around the table and finding out what each needed from the program. As a result, everyone had a stake in seeing it succeed and the program effectively responded to everyone's needs.