

# ELIMINATING DISPARITIES IN CARE

## Case Study: Diabetes Management among the Latino Population

**Project goal:** To effectively manage diabetes, prevent costly and painful complications, and reduce unnecessary hospitalizations.

**Reason for project:** Diabetes was prevalent in the Clinic's patient population and taking a heavy toll on resources. There was a desire to track and demonstrate an effective use of the substantial resources being spent.

**Demonstrable outcome:** By effectively capturing and measuring Clinic outcomes and comparing them among providers, clinic sites and to national quality benchmarks, the Clinic was able to show improved outcomes.

**Sustained accomplishments:** There has been a sustained drop in the average blood glucose levels in an increasing number of patients – a sign of more effective self-management.

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**Organization:** Venice Family Clinic

**Program:** Diabetes Care Management Program

**Hospitals involved:** Venice Family Clinic collaborates with more than 70 health and social service providers, organizations and agencies.

**Location:** Venice, CA

**Summary:** Over 200,000 Americans die from diabetes-related complications each year. Deaths attributable to diabetes have increased by 48% in Los Angeles County since 1991. Mexican-Americans, who comprise the largest Latino population in the United States, are twice as likely to have diabetes as non-Hispanic Caucasians.

The goal of the Diabetes Care Management Program is to effectively manage diabetes, prevent costly and painful complications, and reduce unnecessary hospitalizations. A majority of Clinic patients are Latino immigrants, with low levels of formal education and health literacy.

The program provides culturally competent and comprehensive disease management services free of charge. Strategies include culturally appropriate curricula; health education materials and resource guides that help multiple races and ethnicities better manage their diabetes; and programmatic efforts that include prevention strategies for family members and other at-risk patients, particularly those who are overweight and sedentary.

Program results are positive. Highlights include:

- More patients are being monitored more frequently for blood glucose control
- More frequent check-ups for lower-extremity nerve damage and retinopathy screening
- Vast improvements in the proportion of patients who are actively participating in their care through self-management, goal setting and the use of ancillary educational and supportive services to reduce weight, increase activity and adhere to prescribed diet and medical management
- A sustained drop, over time, of the average blood glucose levels of patients participating in the program

NOTE: Some programs are in the initial stages for data collection and reporting, while others are small in scope and have not yet established benchmarks. Where there is data available, it is provided in the questions and answers below.

### Q&A:

#### 1. How did the organization's leadership know there were disparities in care, i.e., clinical data outcomes, HCAHPS survey, some other mechanism?

Venice Family Clinic's patients are poor and mostly uninsured children and adults, many of them Latino immigrants, with low levels of formal education and health literacy. Seventy-eight percent of patients are minority group members, including 64 percent Latinos, 10 percent African Americans and 3 percent Asians. More than half of the Clinic's patients live below the Federal Poverty Level – living in households earning less than \$22,200 for a family of four. Seventy-four percent have no form of health insurance; 60 percent are women; 25 percent are children and teens; and 16 percent are homeless.

External forces really brought the need for this program to the Clinic's attention. Obesity related health issues were taking over and shifting the Clinic's practice to chronic care. Children were coming in with diabetes and more and more patients were being diagnosed. Diabetes had become so prevalent in the Clinic's patient population; the Clinic wanted to be sure that the resources being spent made a difference.

**2. As you looked through the process, did any other co-morbidity come up?**

Nearly one-third of the Clinic's 16,000 adult patients have one or more chronic diseases or conditions that require multiple medications for effective management, including diabetes, hypertension, coronary heart disease, major depression, asthma, obesity and HIV disease. In addition, 15 percent of the Clinic's 5,500 pediatric patients have chronic illnesses and conditions, most commonly, asthma, but also diabetes, chronic ear infections, obesity, lead exposure and developmental delays.

**3. How did the organization plan interventions and implement the program?**

Initial interventions and implementation structure came from the Health Disparities Collaborative, a national quality improvement initiative for diabetes care management. There was a fairly prescribed and accepted chronic care model that the collaborative used. It was helpful to have that structure provided then tailor it to what worked for the Clinic.

Early on, the program – both interventions and implementation – was so exciting. There were many improvements to be made and positive results were seen quickly. Now, years into it, the goals are smaller and more focused. It's challenging to maintain the excitement. The Clinic has had to get more creative. Interventions are now broken down to specific patient populations – for example, homeless patients where foot care is critical; the Clinic focuses on the foot exam as a key intervention.

**4. What was the time frame, from conception to full implementation?**

Since 1970, the Clinic has provided medical treatment for people with diabetes. When the Clinic joined the Health Disparities Collaborative, there was added focus on prevention and standardization of medical and educational services.

The Clinic began implementation in 2001 on a small scale. Using an electronic registry, the Patient Electronic Care System (PECS), which captures detailed information about patient visits, the Clinic involved only three or four providers. This focus group worked out the bugs and tested the systems. Eventually, the program grew to include a wider group of providers. All told, full implementation took two to three years.

**5. What were the results?**

Results show that the quality of care provided throughout this program is very high. Quality improvements for patients are evident in more patients being monitored more frequently for blood glucose control; more frequent check-ups for lower-extremity nerve damage and retinopathy screening; vast improvements in the proportion of patients who are actively participating in their care through self-management, goal setting and the use of ancillary educational and supportive services to reduce weight, increase activity and adhere to prescribed diet and medical management.

**6. How did the organization assess the outcomes?**

PECS captures detailed information about patient visits and allows the Clinic to track performance and outcomes and compare results among providers, by clinic site and to national quality benchmarks.

The Clinic is no longer responsible for reporting to the Health Disparities Collaborative but outcomes continue to be measured. There is tremendous value to the data. A Quality Improvement team, which includes a diabetes champion, senior leaders and head pharmacists, meets monthly to look at the data to determine where indicators are lagging. The team discusses results of the meeting with providers, getting everyone involved, and then designs an intervention. To measure the intervention, there is a Plan-Do-Study-Act (PDSA) on a small scale. Data is then reevaluated to determine if the intervention was effective.

A dedicated team is very important. They force care to keep up with new clinical guidelines. Accountability to providers, as well as the clinics, is a really useful tool for improving quality of care.

**7. Has there been a sustained improvement since implementation?**

Ongoing assessment allows new goals to be set and achieved. The Clinic has seen continued positive clinical outcomes demonstrated by a sustained drop, over time, of the average blood glucose levels of an increasing number of patients participating in the Diabetes Care Management Program's Quality Improvement Initiative.

Now that the program is established, there are smaller goals to achieve. This becomes challenging, in part because there is a continuing influx of new diabetics, which impact the data negatively.

**8. What challenges or obstacles were overcome?**

One challenge was to get physicians and providers to look at health care from a population standpoint. Typically, health care is done in a one-on-one setting. The value of the registry was that it allowed the Clinic and its providers to take a step back and look at care provided to the population as a whole.

Individually, providers feel a good job is being done because their patients are being treated appropriately; it's a gestalt feeling. But when faced with actual numbers of what is being done for diabetics with foot amputations or blood control as a population, it's hard to accept the data. There is a lot of questioning as to the validity of the data because it doesn't match expectations.

Using the patient registry provided confidence in data and feedback regarding data on patients.

**9. What was the cost of the program and how was it funded (grant, etc.)?**

The Bureau of Primary Health Care supports the program with training support and software (PECS). Many of the services are made possible by an extensive volunteer workforce, both medical and lay staff, as well as generous support from partners, which include hospitals, laboratories, specialty care providers and pharmaceutical companies.

**10. What other stakeholders (i.e., community groups) were involved?**

Providers were key and support staff were integral, particularly the medical assistant staff that preps patients for a physician visit. They started the conversations about self-

management goals and got patients thinking about a more involved role in managing their diabetes.

Staff participates in the quality improvement team and is responsible for getting information back to their departments.

After the Clinic began measuring outcomes, it was clear that the data was able to measure the success of care provided. It was useful to have something objective that pointed to the great job being done.

**11. What advice would you give other organizations wanting to improve care in similar ways?**

Take small steps. Don't take on too much at once. Starting small allows one to measure what's been done which can inform future steps.

Achieve early success upon which you can build.

Diabetes management is expensive and resource intensive. The focus must shift to prevention. If the health care field succeeds in this transition by helping patients implement the necessary lifestyle changes, we will all be rewarded with a reduction in health care disparities.