Chronic Disease Care: Better Ideas for Solving Real World Problems

Go-Local: A Community-Wide Approach

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Los Angeles County is home to over 12 million people, many of whom lack health insurance and rely on the safety net system for health care. Of particular concern to the health of Los Angeles County is the epidemic of obesity and diabetes, which is more prevalent in the Latino population that is now the majority ethnic group in the area. Rates of diabetes are higher in this population (up to 10%, compared to 6% overall). Approximately 500,000 individuals have diagnosed diabetes in Los Angeles County, and another 250,00 to 500,000 have undiagnosed diabetes. In addition, an estimated 3 million have prediabetes.

In order to combat this health program, the Los Angeles County Department of Health Services (DHS) set up a Chronic Resource Management (CRM) Group who chose to focus on treating 3 chronic diseases: congestive heart failure, diabetes, and asthma. The initial part of the process of tackling these chronic problems was to provide funding to three individuals to set up pilot projects for each disease process. I was responsible for setting up the diabetes pilot located at the Roybal Comprehensive Health Center (CHC) in East Los Angeles. The area surrounding the Center is one of the poorest in Los Angeles, with some of the highest rates of obesity and diabetes, in both adults and children. The population at Roybal is 95% Latino.

Over the course of 5 years the Roybal CHC was shown to provide effective diabetes care, with improvements in all parameters studied: blood sugar control (A1C levels), cholesterol levels and blood pressure. Patient received diabetes education and advice on nutrition and exercise. Patients were treated by nurses and nurse practitioners following protocols. A physician supervised the daily activities of the Center.

Based on the success of the Roybal model, a countywide committee was convened to expand the protocols to be implemented throughout the county. Each cluster (major health care area) in LA County was invited to send one endocrinologist and at least one general practitioner, in addition to interested nursing staff, to the committee. Initially we created a uniform county-wide formulary so that patients would have access to the same medications throughout the county system. Next, Dr. James Huang (family practice) and myself chaired the development of the protocols. These protocols were written and revised until all agreed. In addition we created standard forms and prescription pads for diabetes products as well as a method for stratifying patient selection for enter into the program. In its simplest description the system will have two tracks: one for intensive case management and the other for primary-care enhanced diabetes care. Patients will be able to switch in and out of the types of care depending on their clinical status.

Phase one of the program rollout has been the hiring of nurse practitioners and clinical nurse specialists to enhance existing sites of diabetes care. These nurses (approximately 20) were trained collectively through an intensive course run by Project Dulce from San Diego. The nurses have just started working at their designated centers and will begin using the tools and protocols we have written. As they become familiar with the program and act as the beta-test sites for what we have created, more staff will be hired and the program will be expanded.

Important barriers/concerns for the future include a lack of a good computer-based infrastructure for tracking patients and their outcomes. In addition, blood sugar levels tend to increase once patients leave our diabetes programs and return to primary care. Using community workers and promatoras to supplement what is done in the clinics may extend our ability to provide care. Finally, screening for diabetes and prediabetes is not done in the communities, and this will need to be done, and community-based strategies for changing lifestyles will need to be implemented (an issue we are beginning to address through the Keck Diabetes Prevention Initiative).

Take home: 1. Support of local health care administration vital; 2. Process will only work if all involved have input into protocol development; 3. Enhancements for diabetes management in primary care as well as in a patient's home/community need to be provided to sustain outcomes.