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### **Just Do It**

Over the past several years the leadership of many community health centers and public hospitals have recognized the diabetes epidemic and associated health disparities by joining federal collaboratives, creating disease management programs and embracing the Chronic Care Model as a tool for system redesign. At the Alameda County public hospital, however, budget disasters and transient leadership have stymied a comprehensive approach to diabetes. The story of our **Diabetes Management Program** evolves from an attitude that “we just can’t wait”, the use of any and all available resources, and a commitment to provide a health care home for endless uninsured newly diagnosed and poorly controlled diabetics, such as Mr. B.

*Mr. B has a story—not unusual, but heart wrenching and infuriating. He is 51 and has been making a scant living for his family through a small business. Unfortunately, three years ago he was diagnosed with diabetes. At the time he had a private insurance policy that paid for his doctor visits and only cost him \$85 a month. He went to his appointments, took his medications and continued his life. About a year later his insurance company, acknowledging his new chronic illness and the fact that he was approaching a new decade, increased his policy to \$389 a month. Mr. B had no choice—no more insurance, a quickly dwindling supply of medicine, and a sense of foreboding about his future. Only when he felt too weak to work and too bloated to wear his shoes did he go to our emergency department.*

This was the beginning of our intersection. The emergency department was given 6 new patient slots per clinic by our diabetes program. Mr. B’s first visit to our clinic included:

**Diabetes knowledge questionnaire administered by a bilingual volunteer**  
**Physician evaluation and treatment plan**  
**Glucometer given, instruction in use and basic survival skills taught by CDE**  
**Podiatry evaluation**  
**Retinal photographs: follow-up to ophth. within one week if urgently needed**  
**Immunizations**  
**Referral to our weekly self-management classes that alternate between**  
**Spanish and English (patients speaking other languages are appointed**  
**to individual sessions with RD/CDE and RN/CDE)**  
**Entry into our diabetes registry (PECS) by volunteer staff**  
**And in the case of Mr. B—a referral to Renal Clinic**

Creating a program for diabetic planned visits has been very successful for the patients who have participated in our self-management classes.

*Average initial A1c = 12.5*

*Average A1c of program completers = 7.7*

*Patients setting self-management goals = 82%*

*Patients with LDL <100 = 62%*

### **So, how did we do it?**

- The program was created with the understanding that a multicultural, multidisciplinary team is critical to success.
- The team was assembled by finding talented people who sought the excitement of starting a new program in virgin territory.
  - For example: an incredible RD/CDE from La Clinica de la Raza who could spare a few hours a week for ACMC; an energetic “can-do” RN/CDE working at a local hospital who also had 1 day a week free; a renal RN who always wanted to stop the disease upstream; two international medical graduates with passion for improved diabetes care in the Latino community and also able to volunteer; a Primary Care resident and Chief Resident committed to improving care in our diverse community; a Primary Care Program Director who could place those residents in the Diabetes Clinic as a continuity experience, etc, etc.
- Willingness to beg and borrow from any source.
  - For example: meetings with the Health Care Agency Director resulted in a small grant; a grant for the training program partially funded the RD/CDE through a preventive medicine objective; retinal camera purchased through the housestaff patient care fund; renal RN “borrowed” 1 day a week because of the DM training she would receive; negotiated some funding from the Medi-Cal revenue (only 15% of patients), obtained CVDEMS from a government agency, etc.
- Joined the California Quality Improvement Collaborative as the first public hospital-based clinic in California to participate. From this experience we started to incorporate the Chronic Care Model, used PDSA rapid cycle change tools, switched our registry to PECS, and started collaborating more broadly with Public Health and the local community health centers.

### **What is in the future?**

The Diabetes Management Program has been the motivating force for several initiatives:

- Chronic Disease Committee, ACMC medical staff committee: currently working on diabetes, asthma and hypertension
- With the help of a CHCF planning grant, we have broad support for purchase of an integrated registry.
- Collaboration with Public Health and local CHCs for patient self-management programs.
- Kaiser funded ED/inpatient/outpatient diabetes protocols and referral plan

