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Project Dulce and Care Coordination

Reducing Preventable Hospital Readmissions

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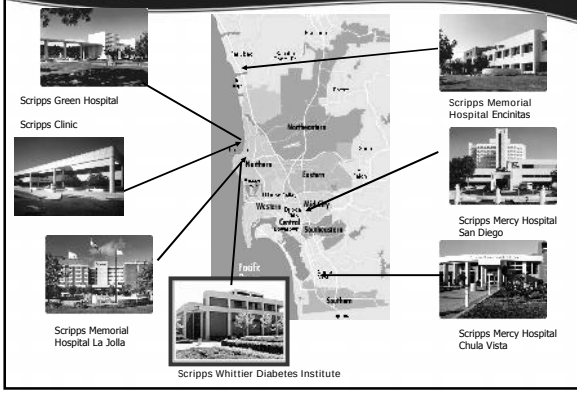

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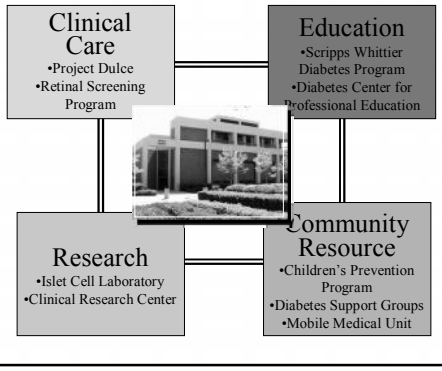
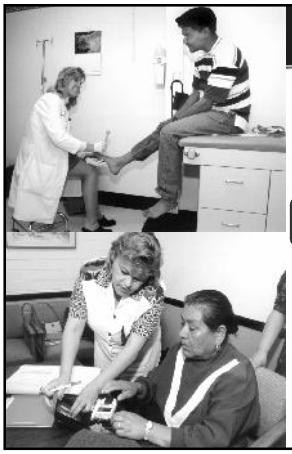
Scripps Whittier Diabetes Institute





Project Dulce

Key Elements

- Multidisciplinary Team Approach Nurse-led
- Peer education (Promotoras)
- Empowered Patients

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Nurse Managed Care

- Clinical management of diabetes, hypertension, lipids
- Physician approved protocols and order sets
- Treatment algorithms (SDM)

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Promotoras

- Learn and Practice
- Make changes
- Solve problems

- Manage their diabetes
- Natural leaders
- Link patient to health system

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Generic materials – not culture-specific

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Documenting Results *(essential to change policy)*

- Electronic Registry
- Clinical and cost effectiveness studies
- Publication

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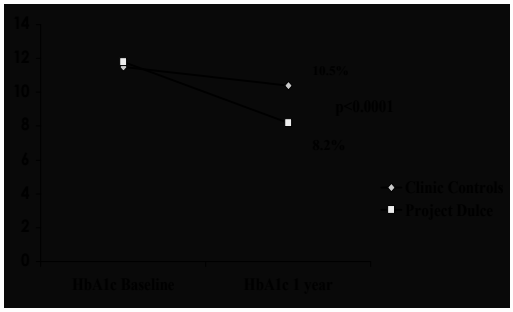
1997 Pilot Results - HbA1c (n: 150, intervention/comparison)



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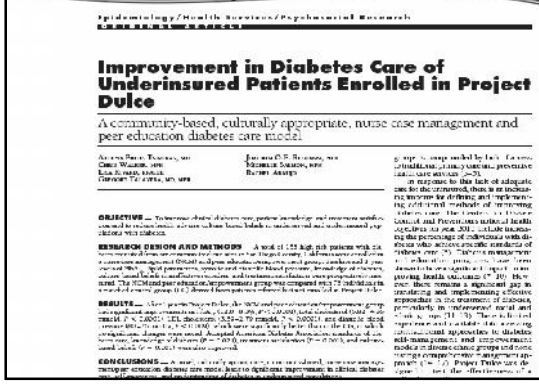
Published Outcomes of Pilot Project



Improvement in Diabetes Care of Underinsured Patients Enrolled in Project Dulce

A community-based, culturally appropriate, nurse case management and peer education diabetes care model.

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Local Policy Change – *County Indigent Care Program*

County stakeholders develop reimbursement system and clinic contracts

Expansion:

- 17 Community Health Centers sites
- 3 University of California-SD sites
- 25,000 served since 2000

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Project Dulce Cost Study, 2004

- Significant improvements in HbA1c, BP, lipids
- Saved 60% in ER/Hospital costs
- Economic modeling over 3 years projects savings of $1,216/patient
- N= 153 intervention group; 153 comparison group

Gilmer T, Philis-Tsimikas A, Walker C. ADA abstract 2004

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Project Dulce Cost Study, 2004

RESEARCH REPORTS

Diabetes

Outcomes of Project Dulce: A Culturally Specific Diabetes Management Program

Todd P. Gilmer, Athena Philis-Tsimikas, and Chris Walker

there is little evidence regarding the clinical effectiveness and costs of culturally appropriate disease management programs.

OBJECTIVE: To determine the clinical outcomes and costs of Project Dulce, a combined stepped-care diabetes nurse case

controls over a one-year period. Subjects included 340 persons with diabetes with coverage under County Medical Services who

changes in clinical outcomes (hemoglobin [Hb] A1c, blood pressure, cholesterol level) and costs associated with participation in

diastolic (0.0 mm Hg; p = 0.001) blood pressure, total cholesterol (20.1 mg/dL; p = 0.001), and low-density-lipoprotein cholesterol

increased. Total costs were higher during the first year of disease management ($5711 Dulce vs $4365 control; p = 0.001).

CONCLUSION: Project Dulce was effective in improving clinical outcomes for control of diabetes and related conditions in a

clinically and economically important and suggests that intervention might provide an immediate benefit to a high-risk population.

KEY WORDS: culturally sensitive, diabetes, disease management.

Published Online, 15 May 2005, www.diabetesjournals.com. DOI: 10.1045/aph.IE503

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State Policy Change

- County proposes Project Dulce model to procure $39M in additional state/federal funds for care to uninsured
- Program expands to 8 additional sites; adds 3,500 people

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RESEARCH ARTICLE

Cost-Effectiveness of Diabetes Case Management for Low-Income Populations

Todd P. Gilmer, Stephane Roze, William J. Valentine, Katrina Emy-Albrecht, Joshua A. Ray, David Cohen, Lars Nicklasson, Athena Philis-Tsimikas, and Andrew J. Palmer

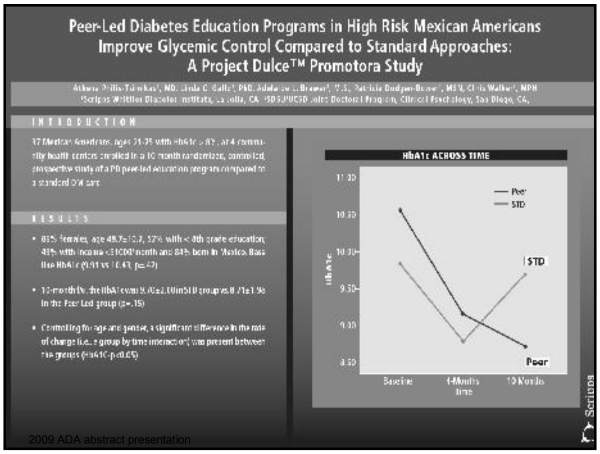
Objective. To evaluate the cost-effectiveness of Project Dulce, a culturally specific diabetes case management and self-management training program, in four cohorts defined by insurance status.

Data Sources/Study Setting. Clinical and cost data on 3,893 persons with diabetes participating in Project Dulce were used as inputs into a diabetes simulation model.

Study Design. The Center for Outcomes Research Diabetes Model, a published,

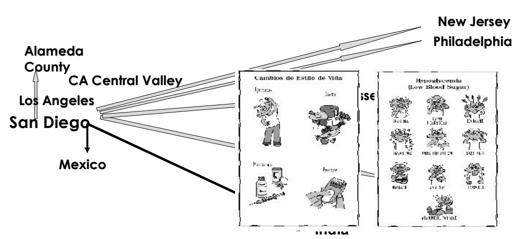
third party payer perspective. Cohort characteristics, treatment effects, and case management costs were derived using a difference in difference design comparing data from the Project Dulce program to a cohort of historical controls. Long-term costs were derived from published U.S. sources. Costs and clinical benefits were discounted at 3.0 percent per annum. Sensitivity analyses were performed.

Principal Findings.



Model Transferred to Multiple Sites

(adapted for local environment)



Scripps Mercy Chula Vista Diabetes Care Coordination Project

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Goal: Improve health of high-risk, hard-to-reach people with diabetes, and decrease unnecessary hospitalizations and readmissions

Target population: (400 over 2 years)

Patients with diabetes admitted to SMCV I/P or ED;

No medical home or lack of follow-up on referral;

Un- or under-funded

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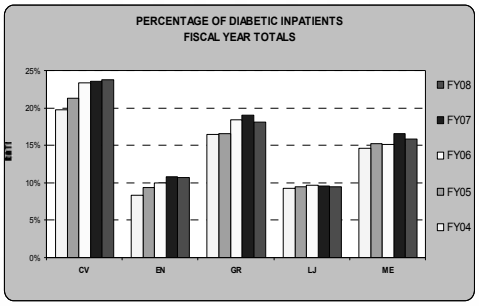
Rates of Diabetic Patients



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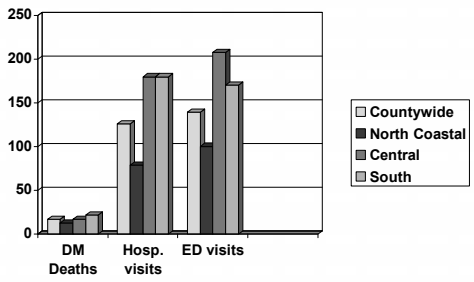
San Diego County Public Health Statistics, 2008



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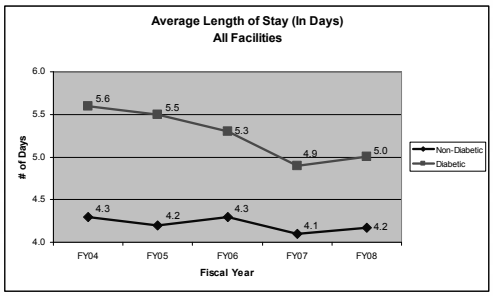
ALOS for Diabetic Patients



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Intervention

- RN identifies patients in hospital; assessment and care plan
- Peer educator conducts home visit; ensures medication access and adherence; connects to medical home
- DSME provided by peer educator in home or in class
- Community health workers in CBO link patients to social services and diabetes prevention resources
- Patient followed weekly or more for 8 weeks, then quarterly for problem-solving if needed

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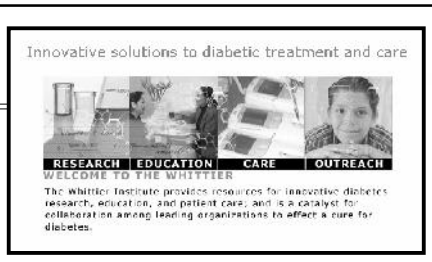
Outcomes

Improved Health	• Clinical indicators • Self management skills • Diabetes prevention for family
Coordination of Care and Care Transitions	• Team care: *hospital nurses, peer educators, community health workers, clinics* • Information exchange • Coordinated care plans
Sustained Program	• Business case – *save inappropriate hospital utilization and cost* • Care coordination system developed and in place



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