Workflow to decrease disparities in Diabetes: a feasibility study

Although continuous glucose monitors are effective at controlling diabetes, disparities among Hispanic populations exist. Using Bree Collaborative guidelines to inform their project, Confluence Health designed a pilot at two clinics to monitor diabetes care disparities by setting up dashboard, providing clinician education, and designing new workflows for the use of CGM's and referrals.

Background and Setting

Confluence Health sits in a rural area serving a high agricultural and migrant demographic. Our population is low on the socioeconomic scale (our payor mix is majority Medicare/Medicaid). Our services span four counties (Chelan, Douglas, Grant, Okanogan) with a total population base of approximately 269, 872. Confluence had observed disparities in uncontrolled diabetes among AA/AIAN/Hispanic patients since 2021.

In 2023, Confluence Health joined the Bree's Health Equity Action Collaborative with the aim of developing an intervention for diabetes care disparities.

Tools and investment

- Staff time (endocrinologist, VP of safety, providers, quality team), including monthly meetings for the pilot team
- Workflow for clinic to order and download CGM data
- Desktop computers with USB port to enable downloading of CGM readings for people who don't use their phones (elderly, Medicare, etc.)
- Dashboards
- Educational Materials- Diabetes Resource Toolkit

Advice

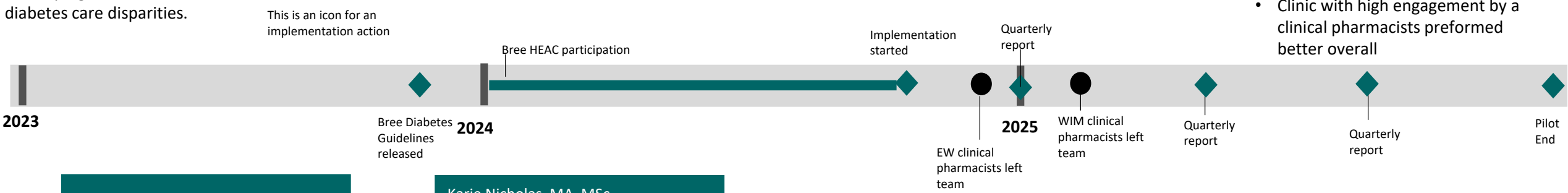
- Providers need to be comfortable to treat diabetes, including how to prescribe and dose insulin – more education is necessary to prevent clinical inertia and should be started early in an improvement project
- Include clinical pharmacists or diabetes educator on care team
- Ensure that providers are prescribing medication or treatments that patient can afford and would still be effective
- Incorporating CGM's requires multiple levels of staff engagement (administration, reception, IT, clinicians, etc.)

Implementation

- Two educational sessions to providers in two clinics and distribution of toolkits
- Dashboard development in Epic and quarterly report out
- Quarterly patient recommendations to providers for AA/AIAN/Hispanic patients with uncontrolled diabetes after chart reviews by endocrinologist
- Workflow design for ordering and downloading CGMs in two primary care
- Pharmacists included in monthly meetings
- Clinic manager lead IT implementation and changes

Outcomes and impact

- Increase in provider education
- Implementation of CGM ordering and download workflow at one clinic
- Increase in CGM utilization
- E. Wenatchee reductions in uncontrolled diabetes: 11% Hispanic, 17% non-Hispanic, 57% African American, 13% American Indian/Alaska Native
- Wenatchee IM uncontrolled diabetes changes, 40% increase Hispanic, 2% decrease non-Hispanic, 13% decrease American Indian/Alaska Native
- Decreases in disparities at E. Wenatchee clinic
- Clinic with high engagement by a clinical pharmacists preformed better overall



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