Workflow to decrease disparities in Diabetes: a feasibility study

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Abstract:

Introduction/Background: Confluence health developed a new workflow aligned with best practice recommendations from the Bree Collaborative. The intervention leveraged CGM data, clinician education, and support from an endocrinologist and was implemented in one clinic in Wenatchee, Washington.

Objectives: The objectives were to test the feasibility of the workflow and to determine if the intervention has the potential to reduce race and ethnicity disparities for diabetes control.

Methods: Patients were Hispanic, African American, American Indian and Alaska Native and other minority with a diagnosis of Diabetes and receiving care at Confluence Health. Workflow implementation included education on new workflow and best practices for using CGM data in the clinic. Chart reviews and recommendations were conducted by an Endocrinologist. Patient data was collected and analyzed by clinic staff.

Results: East Wenatchee clinic conducted a successful implementation of the new workflow with 70% of providers implementing the new workflow. Wenatchee Clinic also saw reductions in uncontrolled diabetes among the intervention target populations of -2.3%.

Discussion/Conclusion: This feasibility study was able to demonstrate that workflows using GCM data in clinics are feasible and that they have the potential to improve diabetes control and reduce disparities in control. Care team composition may be critical to success and the workflow needs to be tested more broadly before drawing conclusions about it patient level effectiveness.

Introduction and Background

Although the prevalence of diabetes in Washington State is relatively stable, it is a significant health condition, as the 7th leading cause of death in the state. The burden of diabetes is also unequally distributed, being highest in the Medicaid population. (1) Disparities also exist for many minority populations and people of color regardless of insurance status. Those with “Hispanic heritage are twice as likely and African Americans are 1.6 times as likely to have diabetes as whites”. (1)

In 2023, the Bree Collaborative selected diabetes care as a topic to help improve access to care and treatment in Washington state. Included in the Bree report were recommendations for clinicians that included the following:

- Diabetes devices should be considered, such as blood glucose monitors (BGMs), continuous glucose monitors (CGMs), insulin pumps, or automated insulin delivery (AID) systems, as therapy tools to assist with the management of diabetes
- Educate the patient on diabetes self-management, medication management, healthy lifestyle options, and where to receive support and resources. Ensure education is culturally relevant and linguistically inclusive. (2)

To support the implementation of its guidelines, the Bree Collaborative hosts a Health Equity Action Collaborative (HEAC) where organizations can design and implement Bree recommendations with a focus on health equity. In 2024 Confluence Health joined the HEAC and developed a pilot project to address disparities in diabetes care at their clinics. (3)

Confluence Health is a non-profit health care system with a 12,000 square mile service area in North Central Washington state. It employs just over 4000 employees, over 300 physicians (in partnership with Wenatchee Valley Medical Group) across 30+ specialties and over 170 advanced practice clinicians. Confluence Health operates a Level III Trauma Hospital (Central Campus) and a smaller inpatient rehabilitation facility (Mares Campus) with just over 200 beds combined. The organization is governed by a 6-person Executive Team and a 14-member Board of Directors. (2)

Confluence Health sits in a rural area serving a high agricultural and migrant demographic. The population served at Confluence is low on the socioeconomic scale with a payor mix that is majority Medicare/Medicaid and the demographic makeup in 2024 included 73% of individuals identifying as White/Non-Hispanic, 32.4% identifying as Hispanic/Latino ethnicity, 2.4% of identifying as American Indian/Alaska Native and 0.5% identifying as African American.

Their services span four counties (Chelan, Douglas, Grant, Okanogan) with a total population base of approximately 269, 872. (2)

As a core part of their primary care services, patients at Confluence receive services to screen for and identify diabetes and care to control Type 1 and Type 2 diabetes. These services include diabetes education, lifestyle counseling, medication prescribing, and management of diabetes, including prescribing and managing continuous glucose sensors. In addition, care for diabetes control is over seen by an endocrinologist who provides analysis and feedback to providers to help them with optimal treatment.

Problem statement and research questions:

In 2024, Confluence identified disparities in the percentage of uncontrolled diabetes among our patients with diabetes, with double the rate of uncontrolled diabetes among patients who are Hispanic, Black, or American Indian/Alaska Native, in comparison to patients identifying as non-Hispanic and white.

What was the goal of the implementation?

The pilot project Confluence developed as part of the HEAC was designed to explore the feasibility of a new workflow that included review by an endocrinologist and use of CGM data, with the aim to reduce the disparity in rate of uncontrolled diabetes (defined as Hemoglobin A1C>9%) between Hispanic, Black, and American Indian/Alaska Native patients in comparison to Non-Hispanic patients.

Confluence set a target of a reduction in uncontrolled diabetes for African American, American Indian/Alaska Native, and Hispanic patients by 50% over the course of one year in the East Wenatchee clinic site. In the Wenatchee Internal Medicine clinic, there were no African American patients with uncontrolled diabetes. So, the goal in the Wenatchee Internal Medicine clinic was to reduce the disparity by 50% for Hispanic, American Indian patients, compared to non-Hispanic white patients over the course of one year.

When did the work take place?

The preparation of the implementation plan began in January of 2024. Implementation of the plan started in October of 2024, and the observation period ended in October of 2025.

Table 1. Timeline of project development and implementation.

2023	Bree Collaborative Diabetes Care Guidelines developed
2024	• **January -** Pre-planning; implementation plan developed through Bree HEAC participation • **February** – Monthly meeting of the diabetes disparity action plan and continuous glucose sensor implementation multidisciplinary team • **March** – Clinic workflow of continuous glucose sensor downloading and ordering created • **April** – Review of needs for clinics to have desktop computers for clinics to download continuous glucose sensor data for patients who don't use cellular phones to scan • **May** – Monthly meeting of diabetes team • **June** – Education Talk #1 with East Wenatchee Family Medicine physicians and healthcare providers about American Diabetes Association pharmacotherapy guidelines and continuous glucose sensor interpretation • **July** – monthly meeting of diabetes disparity action plan team • **August** – monthly meeting of team • **September** – monthly meeting of team • **October** - Implementation and observation period began • **November** - Clinical pharmacist for East Wenatchee leaves Confluence Health and this position is not filled for duration of implementation period. • **December** – Educational Meeting for providers
2025	• **January** – Monthly meeting of Diabetes team • **February** – Educational Talk #2 for providers in East Wenatchee Family medicine to review ADA pharmacotherapy guidelines with emphasis on dosing and prescribing insulin and continuous glucose sensor interpretation. • **March** – Diabetes Resource Toolkit provided to clinic in English and Spanish. Clinical pharmacist for Wenatchee Internal Medicine leaves and the position is not filled for duration of implementation period. • **April** – Continued work on clinic workflow for continuous glucose sensor downloading • **May** – monthly meeting • **June** – monthly meeting • **July** – monthly meeting • **August** – Education Talk #3 with Wenatchee Internal Medicine healthcare providers about ADA guidelines and continuous glucose sensor interpretation. • **September** - • **October-** observation period ended

Methods

Confluence Health conducted an observational pilot study to test the feasibility and patient-level outcomes of a Bree aligned workflow, using pre-post intervention measurement to quantify the patient level impact.

Intervention Components

Educational changes:

Educational meetings with Primary Care providers to review the American Diabetes Association 2024 Guidelines for pharmacotherapy and to review continuous glucose sensor interpretation and insulin initiation and prescribing were held on two occasions: 12/2024 and on 2/18/2025

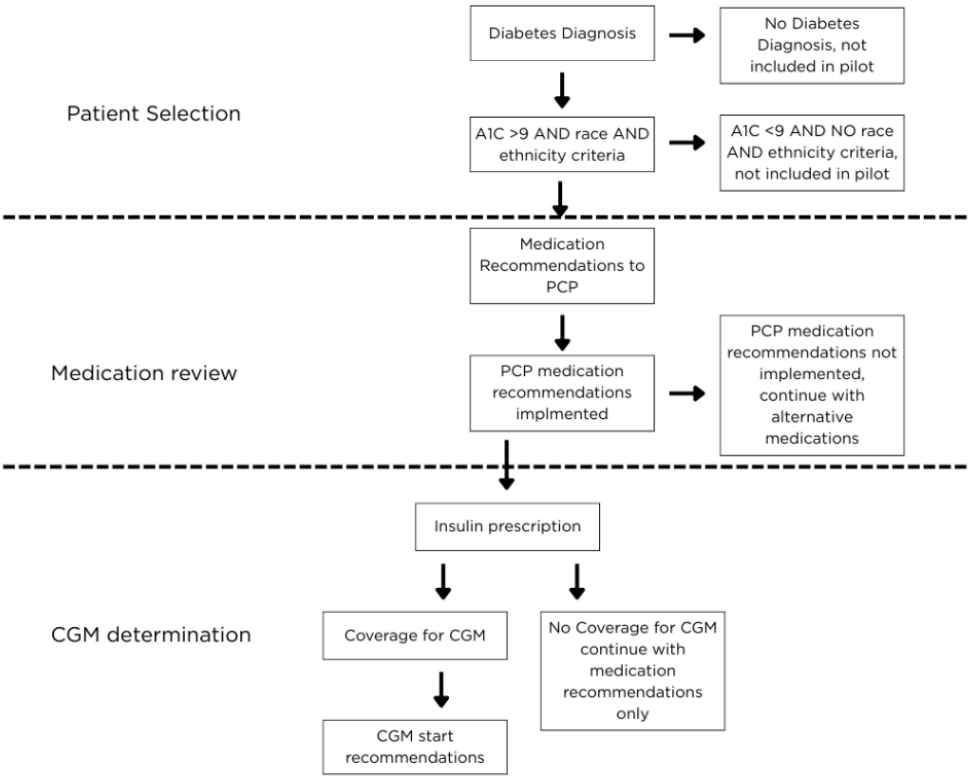
Distribution of a Diabetes Resource Toolkit focused on resources for Hispanic individuals with Diabetes in our region (including information on resources about food insecurity, help with transportation, and diabetes education) to providers to give to patients who many need it. *This diabetes resource toolkit was created in collaboration with University of Washington Masters of Public Health students.

Workflow changes:

Provider education and participation in project development included creation of a workgroup to lead this work consisting of physicians, diabetes educators, clinic managers and quality analysts. We had monthly meetings to discuss progress and next steps.

Creation of a workflow to download continuous glucose sensors and to order continuous glucose sensors in the primary care clinic with Confluence Health. The workflow included processes to prescribe continuous glucose sensors for those on insulin whose medical plans could cover the cost. Clinicians were taught to download CGM sensor data in-clinic, how to review it with the patient, and helped to make necessary changes to medication based on the sensor data. This help was provided by quarterly chart reviews by endocrinologist for Hispanic, Black, and American Indian patients whose Hemoglobin A1C was greater than 9% and recommendations on medication changes were given by an endocrinologist to the primary care provider. Charts were also reviewed for CGM use.

Figure 1. Diabetes care pilot intervention processes flow.



Resources

Purchase of two desktop computers for the clinic to enable downloading of continuous glucose sensor readers for patients who did not use their phone with their continuous glucose sensors.

Data Collection and analysis methods

Confluence Health collects information on race and ethnicity as a regular course of care through patient self-report surveys provided at registration and entered into the patient record in MyChart.

A1c control, medication, and other patient demographics data such as age, gender, insurance, etc. were collected monthly by the staff endocrinologist using patient chart

abstractions from Epic. Patients were stratified by race and ethnicity. Uncontrolled diabetes was defined as patients with a diagnosis of diabetes and a recent measure of Hemoglobin A1C >9%. For the analysis at the population level, data was aggregated and calculated as a proportion of all patients with a diagnosis of diabetes.

CGM data was collected through a workflow developed by Confluence and downloaded by the provider (See Appendix A).

Periodically throughout the study, the individual charts of patients who were Black, American Indian, or Hispanic who had a Hemoglobin A1C>9% were reviewed for medications listed, Hemoglobin A1C, and payer type. Chart reviews were not conducted for those who were white/non-Hispanic.

Post-hoc review of patient records were conducted to determine loses to follow-up and data was collected on aggregated diabetes control for all patients with a diagnosis of diabetes at confluence clinics.

Patient level data was de-identified and analyzed post-hoc using Stata 18 BE. Patient demographic variables were examined for differences in distribution using Chi-squared tests for each age group. Histograms were used to examine age and A1c at the start and end of the study. A new A1c 2024 variable was created that included only those who had a final measurement. Wilcoxon signed-rank tests were used to test pre-/post-A1c changes for the portion of patients who had an A1c documented at the start and end of the study. Failure rates and time in study were calculated using person-years in Stata.

A complete case analysis was conducted with patients who had both an initial and a final A1c. Chi-squared tests were used to determine any statistical difference in distribution for A1c control by age group, medication type, insurance type and between patients who were defined as a “complete case” (those who had an A1c measured at the start and end of the study period) and those who were defined as an “incomplete case” (no final A1c measure).

Results

Provider Training Outputs and Outcomes

There were ten (10) total providers that participated in the pilot study. Results of the implementation are shown below (Table 2.).

Table 2: Implementation of intervention and GCM workflow at East Wenatchee Family Medicine (a.k.a. East Wenatchee Clinic).		
	N=10	%
Number of training courses available	3	N/A
Standardized patient materials created for intervention	1	N/A
Chart reviews done (Hispanic, Black, and AIAN with A1c>9)	88	N/A
Number of providers receiving training	10	100%
Number of providers receiving materials	10	100%
Number of providers/clinicians that KNOW HOW to operationalize the new workflow	9	90%
Number of providers/clinicians that DID operationalize new workflow	7	70%
Number of providers implementing patient facing materials	10	100%
Number of providers implementing medication review recommendations (prescriptions)	8	80%

Patient outcomes

There were 82 patients who met the inclusion criteria for the feasibility study. All patients had an A1c documented at the beginning of the study and chart reviews were conducted for them at least once during the study period. All patients on insulin (29.8%) received a review for the use of a CGM. A portion of patients (complete cases), 46.3%, had a final A1c reading at the end of the study period. Age and medication types were the only variables that differed between complete cases and incomplete cases, with complete cases being more likely to be older and to have an insulin prescription (see Table 3).

All patients who were older were statistically significantly more likely to speak Spanish as a preferred language than younger patients (P= 0.021).

Medication distribution was not significantly different by age with the exception glipizide; patients age 45-64 being more likely than other age groups to have a prescription (p= 0.016).

Table 3: Demographics of patients who received the intervention during the pilot study period, count and percent, by complete case status, p-value for chi-squared test for differences in distribution between complete cases and incomplete cases.							
N=	East Wenatchee (n=82)		Complete case (n=38)		Incomplete case (n=44)		
	#	**%**	**#**	**%**	**#**	**%**	***P*=**
Age							
18-44	21	25.6%	8	21.1%	13	29.6%	
45-64	30	36.5%	17	44.7%	13	29.6%	
65+	14	17.1%	12	31.6%	2	4.6%	
Missing	17	20.7%	1	2.6%	16	36.4%	**0.021**
Race/ethnicity							
Hispanic	71	86.6%	36	94.5%	35	79.6%	
African American	5	6.1%	2	5.3%	1	2.3%	
American Indian/Alaska Native	3	3.7%	0	0.0%	5	11.4%	
Unknown/Missing	3	3.7%	0	0.0%	3	6.8%	0.093
CGM use							
Yes	13	17.1%	9	23.7%	4	9.1%	
No	63	82.9%	27	71.1%	36	81.8%	
Missing	6	7.3%	2	5.3%	4	9.1%	0.178
Payor Type							
None	14	17.1%	6	15.8%	8	18.2%	
Private	40	48.8%	16	42.1%	24	54.6%	
Medicare	11	13.4%	9	23.7%	2	4.6%	
Medicaid	2	2.4%	1	2.6%	1	2.3%	
Missing	15	18.3%	6	15.8	9	20.5%	0.163
Insulin Pump							
Yes	1	1.2%	0	0.0%	1	2.3%	
No	77	93.9%	37	97.4	40	90.9	
Missing	4	4.9%	1	2.6%	4	6.8%	0.430
Medication Type							
Insulin	23	28.0%	15	40.5%	8	20%	**0.049**
Metformin	53	42.6%	23	60.5%	30	68.2%	0.227
GLP-1	24	29.3%	11	28.9%	13	29.6%	0.460
glipizide	22	26.8%	15	39.5%	7	15.9%	**0.039**
Other	31	37.8%	20	52.6%	11	25.0%	**0.028**
Number of medications							
0	2	2.4%	1	2.6%	1	2.3%	
1	13	15.9%	6	15.8%	7	15.9%	
2	16	19.5%	9	23.7%	7	15.9%	
3	16	19.5%	12	31.6%	4	9.1%	
4	6	7.3%	6	15.8%	0	0.0%	
missing	29	35.4%	4	10.5%	25	56.8%	**<0.001**
Patients lost to follow-up	6	7.3%	0	0.0%	6	100.0%	**<0.001**

Of the 13 individuals who had a CGM during the study, 9 were complete cases with an A1c measure at the end of the study period. Of the 9 completed cases, 33.3% obtained A1c control. Person-time at risk for those with and without a CGM was 5.2 years of total PT with a failure rate of 1165.1 per 1000 PYR and 14.5 years of total PT with a failure rate of 691.4 per 1000 PYR, respectively.

Diabetes Trends During Study Period

Overall, the prevalence of uncontrolled diabetes at all Confluence clinics increased during the study period. Patients with an insulin prescription were no more likely than those who received only medication review to have A1c control (p= 0.194).

Conversely, East Wenatchee Family Medicine experienced reductions in the proportions of all patients with uncontrolled diabetes, while Wenatchee Internal medicine saw no change or increases in patients with uncontrolled diabetes for both Hispanic and non-Hispanic white patients.

Table 4: Percent and number of Hispanic and non-Hispanic, white patients with A1c >9%, pre and post intervention, by clinic and overall.,

	East Wenatchee Clinic					All confluence clinics				
	October 2024		October 2025		% diff.	October 2024		October 2025		% diff.
	%	N=	%	N=		%	N=	%	N=	
Patients with Hgba1C>9% for patients identifying as non-Hispanic	10%	1120	8.3%	1203	-1.7%	8.1%	N/A	8.3%	7730	+0.2%
Patients with HbA1c to >9% for patients identifying as Hispanic	20%	255	17.7%	288	-2.3%	16.0%	N/A	16.3%	1893	+0.3%

The percent change in diabetes control at East Wenatchee was more pronounced among Hispanic patients, who had received the intervention, compared to non-Hispanics, who did not receive the intervention. Diabetes control trends were different for all patients at East Wenatchee Clinic compared to the overall trends at Confluence Health.

Discussion

The project protocols demonstrated high fidelity with Bree Collaborative best practice recommendations, including:

- diabetes care team following health system clinical pathways and/or protocols for treatment and management of diabetes that follow the most updated clinical guidelines (2024 and 2025 ADA Standards of Care).
- Use health systems registry for patients with diabetes to track and address gaps in care
- Development of a plan for glycemic monitoring and pharmacologic management
- Use of Diabetes devices, such as blood glucose monitors (BGMs), continuous glucose monitors (CGMs), insulin pumps, or automated insulin delivery (AID) systems, as therapy tools to assist with the management of diabetes.

The researchers are unable to determine how much success of implementation among providers at East Wenatchee clinic was due to the team structure and how much can be attributed to the Bree guidelines, due to lack of a comparison group for team structure. Although Confluence used the Bree guidelines to design their intervention, the Bree staff is not yet able to validate our score cards to measure the level of fidelity the intervention had with Bree recommendations.

At the start of the pilot program, East Wenatchee clinic had one clinical pharmacist who would see all patients with diabetes whose Hemoglobin A1C>9% for follow up appointments. She was also the initial project champion and the only one who knew how to order continuous glucose monitors and download the data from them at the start of the project. She was also able to teach others in the clinic this skill, which led to an increase in the use of the workflow in that clinic. The clinical pharmacists left the clinic by December of 2025.

Delivery of the intervention components (diabetes education and workflow) was 100% and uptake by providers was robust. Only three providers could not fully implement the new workflow and only two of those declined to use the medication review recommendations. This resistance has been largely attributed to clinical inertia base on the experience of the endocrinologist that was working with clinicians, although Confluence did not collect data on clinician experiences.

This case study was able to collect aggregated data from other Confluence sites and patient populations for reference, to add context to the patient experience at East Wenatchee Clinic. Conclusions cannot be drawn from this data about the variables potentially influencing the outcomes for patients at Confluence as a whole, or for those receiving the intervention and it limits the extent to which we can discuss differences

between East Wenatchee clinic and overall trends at Confluence Health. However, it does illustrate that East Wenatchee clinic had a substantially different outcome for all patients with diabetes.

The ramp-up to learn how to order the continuous glucose monitors and download the data took time for the physicians in the East Wenatchee clinic. After the departure of the clinical pharmacist there was not as much availability for follow-up appointments or insulin education. Many of the physicians were not comfortable starting a patient on insulin without the clinical pharmacist's input and appointment capacity.

Because this pilot focused more on the feasibility of the protocol, data collection on patient outcomes was focused on patient care rather than on the study design. However, patient outcomes point towards effectiveness of this workflow to control A1c. Patients joining the clinic later on in the study likely did not receive the same "dose" of intervention as those who were being treated from the start. These were also not all new incidents of Diabetes, which would also skew patient results towards the null.

Reductions in the proportion of eligible patients with uncontrolled diabetes was achieved at the East Wenatchee Family Medicine clinic for all patients, and greater improvements were seen in Hispanic patients compared to the white, non-Hispanic patients. This suggests some effect of the intervention, since all Hispanic patients received the intervention. However, there was a reduction for all patients at the East Wenatchee clinic despite an overall trend towards stable or slightly increasing numbers of patients with uncontrolled diabetes across all Confluence sites.

Medication and age were both important factors in this study. The complete cases were heavily skewed towards older patients and patients receiving insulin or glipizide, however neither age or medication type were associated with A1c control at the end of the study. Of the complete cases, patients with a CGM had no greater odds than those without one of reaching A1c targets, however failure rate (not reaching control) was greater among those with a CGM. This is likely due to the short amount of person-time the CGM patients had in the study. They were taken into the study at a later stage and did not have enough time to reach a controlled state.

The post-hoc review showed that patients who were lost to follow up or who did not have a payor listed in the medical record were more likely to identified as Hispanic ethnicity than expected. It is unclear what the cause of this was, however during 2025 concerns about immigration enforcement were intensified in the area and may have contributed to patients not making follow-up appointments or sharing all their information. Small numbers for African American and American Indian/Alaska Native patients limits the ability to draw any conclusions about statistical significance and changes over time of this study could be due to chance alone.

Lessons Learned

Clinical inertia is a barrier to consider when implementing new workflows.

The chart review process revealed that clinical inertia was seen as something that strongly affected staff's willingness to change prescribing practices and there was resistance to accelerating pharmacotherapy when treatment was not working. To address this barrier, several education sessions for the healthcare providers were implemented, focusing on how to effectively implement the ADA guidelines for pharmacotherapy for patients, however no follow-up with providers was conducted, thus important information on this barrier may have been lost.

Collaborating with payors is important to be able to fully implement Bree recommendations.

Payors played a key role in whether a patient was eligible for and received a CGM, even when clinical decision making determined that CGMs would be helpful. Insurance or lack thereof, was a major barrier to implementing and demonstrating the effectiveness of the clinical use of CGM data. By contrast, provider use of CGM data in the clinic was a solvable barrier and required relatively few resources to implement.

Administrative staff and Clinical Pharmacists are a key part of implementation.

Gaining the ability to download data from CGMs required multiple set-up steps that involved administrative assistance to start effectively ordering and using continuous glucose sensors. Once the process was in place, the sustainability of a CGM data download workflow was feasible.

Having a specific role of clinical pharmacist on the team was important for the comfort of the providers to pursue more aggressive medication treatments and supported better outcomes in patients, however the medication review component of the intervention was staff intensive.

Planning out the evaluation concurrently with the design of the implementation can provide more robust data to inform change.

It is possible to measure differences in small groups however the design of this implementation didn't plan for statistical tests. This study was under-powered to detect outcome differences and was not randomized. Conducting a feasibility study that includes information on effectiveness regarding patient outcomes may be important to help provider buy-in and should be considered at the point of the study design.

Conclusions and recommendations

This study was able to demonstrate that alignment with Bree recommendations and the use of GGM data to manage diabetic patients is feasible and has the potential to be successful. This small subset of patients was chosen because their risk of continuing uncontrolled diabetes was high and chart review is resource intensive intervention to address this risk. Implementing this type of process for entire health systems and all diabetic patients will require additional changes to the workflow presented here, as well as a system-wide quality improvement approach and appropriate staff (endocrinologist, clinical pharmacist).

Health care organizations may want to consider other ways to support providers in more aggressive medication treatments or focus on only patients who are insulin dependent to implement the CGM use part of this pilot. Future studies should focus on provider's experiences with workflow changes, specifically focusing on clinical inertia and provider-perceived barriers to patient care.

It is recommended that anyone conducting a similar feasibility study in their clinics that include patient outcomes consider adequate sample sizes, comparison groups, robust patient outcome measures, including patient experience data, as part of their evaluation strategy.

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Appendix A

Clinic Workflow for Continuous Glucose sensor downloading (developed by Dr. Kathryn Eren in the East Wenatchee Family Medicine clinic)

1. Any patient who has a continuous glucose sensor would have a flag in the patient information section indicating that they have a continuous glucose sensor.
2. When the patient arrives for their appointment, the receptionist would see the flag and ask the patient for their sensor if they did not use their phone to scan their continuous glucose sensor. If the patient used their phone for scanning the sensor, the receptionist could download the sensor data online. If the patient was using the handheld physical continuous glucose scanner for obtaining glucose readings, the patient would give the scanner to the receptionist, and the receptionist would plug in the scanner to the desktop to obtain a download of the information.
3. The receptionist would scan the download in a digital format and send it to the physician or other healthcare provider who would be seeing the patient for their clinic visit.
4. The physician or other healthcare provider would be able to open the uploaded continuous glucose sensor from the patient's electronic medical record and review it prior to or during the appointment.