Diabetes Collaborative Care Launch

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Background

Concern: Diabetes continues to be one of the most common chronic diseases in the United States with 90% of cases being caused by type 2 diabetes, leading to microvascular and macrovascular complications that cause significant mortality, morbidity, and strain on our healthcare system[1]. Analysis of baseline data at UCSF in July 2022 showed across all race/ethnicity groups, 259/913 (28.4%) of patients with diabetes had HbA1c >9% or missing HbA1c values.
Literature on collaborative care models in diabetes have shown improved glycemic control, patient outcomes, and patient self-management in diabetes with pharmacist, nurse, and health-navigator led interventions.[2,3]

Population: UCSF patients with San Francisco Health Plan (SFHP), a managed Medi-Cal insurance plan, with type 2 diabetes.

Gap analysis: With a health equity first approach, a disparity in the Latinx population was identified. Latinx patients had higher rates and overall numbers of patients with HbA1c > 9% or with missing HbA1c levels 45/131 (34.4%).

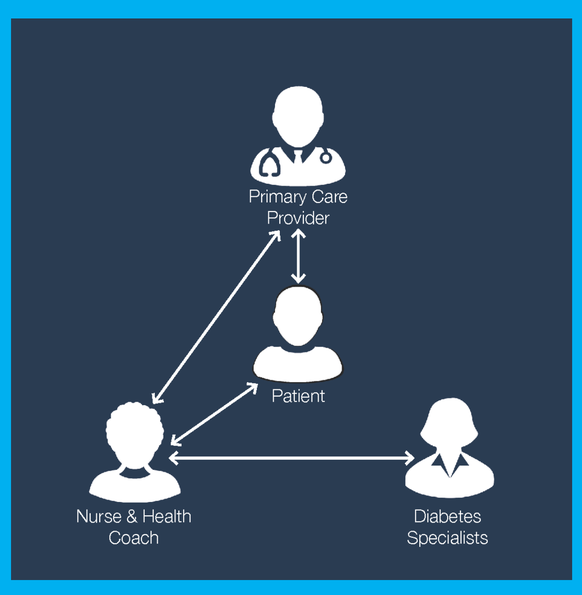
[1]Chatterjee, S., Khunti, K., & Davies, M. J. (2017). Type 2 diabetes. *The lancet*, *389*(10085), 2239-2251.
[2]Crowe, M., Jones, V., Stone, M. A., & Coe, G. (2019). The clinical effectiveness of nursing models of diabetes care: A synthesis of the evidence. *International Journal of Nursing Studies*, *93*, 119-128.
[3]Coleman, K. J., Magnan, S., Neely, C., Solberg, L., Beck, A., Trevis, J., ... & Williams, S. (2017). The COMPASS initiative: description of a nationwide collaborative approach to the care of patients with depression and diabetes and/or cardiovascular disease. *General Hospital Psychiatry*, *44*, 69-76.

Project Goals

Our goal was to bring an innovative evidence-based collaborative care model to bridge the gap for Latinx people with diabetes who are not reaching target goals. This model is a nurse and health-navigator led program that provides patients with additional resources and support like diabetes education and health coaching, while also presenting cases to an endocrinologist and a specialized diabetes educator to consult and provide clinical recommendations for patients.

Program's SMART goals:
- Phase 1:
  - Outreach to 100% of patients who meet enrollment criteria
- Phase 2:
  - Of the patients enrolled for 6+ months, more than 50% of patients will have a decrease in HbA1c by 0.5% points by end of program enrollment
  - 100% of enrolled patients will be screened for food insecurity. Of those who screen positive for food insecurity, 100% will be offered/ referred to local resources within 3 months of enrollment

PROBLEM STATEMENT: UCSF Latinx patients with SFHP insurance have higher rates of HbA1c > 9, which increases their risks of mortality and morbidity from micro and macrovascular disease, including retinopathy, nephropathy, and higher rates of cardiovascular disease.



We launched a multidisciplinary initiative to mitigate DM2 health disparities in our Medi-cal population that outreached to 57 patients with a 21% enrollment rate.

Project Plan and Intervention(s)

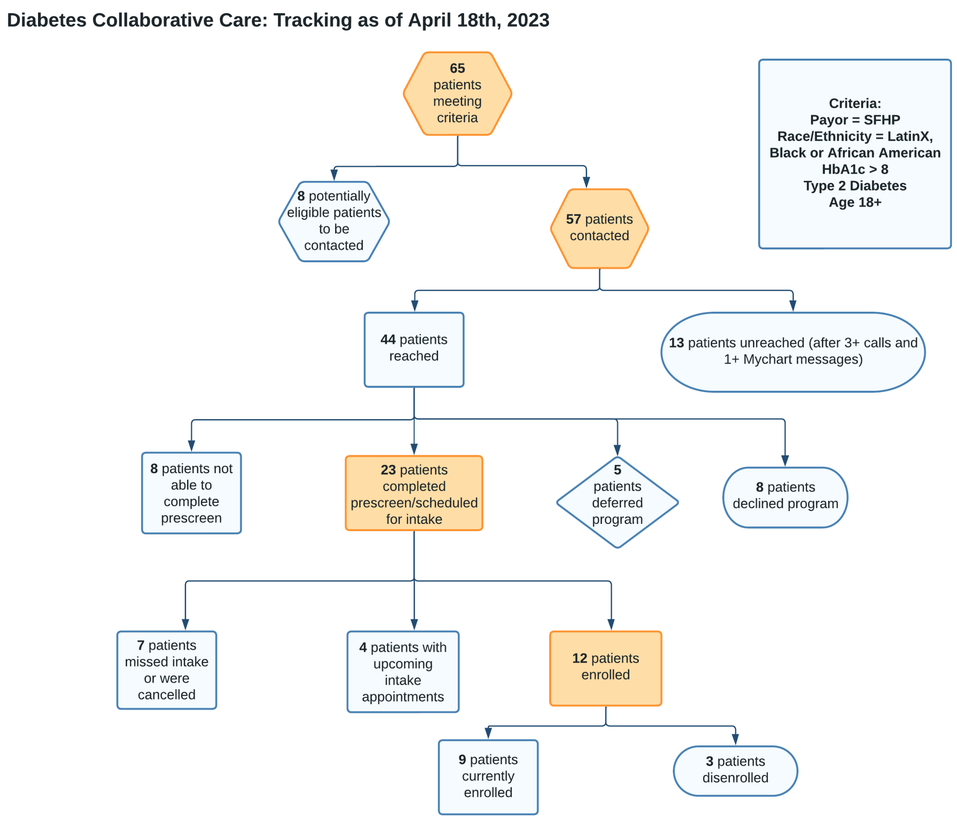
Hypothesis: A collaborative care model adapted for diabetes will improve glycemic management among enrolled patients.
Patient identification: Ongoing use of an Apex workbench report and chart review to identify patients who meet program criteria (n=65)
Model: Predicted enrollment up to 1 year with weekly outreach in the first 4-6 months then less frequently as patient moves through phases of program.

Prior to launching:
- Kickoff meeting 8/8/22
- Defined inclusion and exclusion criteria
- Developed process for HCN to recruit patients
- Worked with an Apex analyst to develop tools specifically for program
- Created smartphrases for HCN prescreen, RN intake, case conferences and follow up calls
- Developed a program flyer
- Launched 11/16/22

Obstacles after launching:
- Overlap with other programs in OPH
- Low enrollment rate
- High degree of social needs
- Keeping consultants within their allotted FTE
- Confusion in primary care regarding scope of program
- Lengthy RN intake

How obstacles were addressed:
- Met with other programs addressing diabetes to define intersection
- Expanded target population to include Black or African American patients
- Collected a resource bank
- Adjusted case conference structure
- Started monthly steering meetings to make ongoing programmatic decisions
- Edited intakes to include most high yield questions

Project Outcomes, Results & Impact



Phase 1 Goal: outreach to **100%** of eligible patients
Outcome: outreached to **88%** (57/65) with plan to contact all 65
Enrollment rate: **21%** (12/57)

Conclusions, Next Steps, & Lessons Learned

Next Steps:
- Establish regular reporting process for HbA1c values and food insecurity referrals for Phase 2
- Expand outreach to other race/ethnicity groups within SFHP
- Provide further diabetes training, including management and behavioral aspects of care
- Automate recruitment with Cipher calls/texting and bulk flyer messages
- Pick screening tools for alcohol and substance use, provide SBIRT training to clinical team and develop process for patients who screen positive
- Explore functionality required to display DCC weekly appointments in patients' MyChart

Lessons Learned:
- Launching a new program takes time and collaboration among many disciplines
- Once launched, there needs to be a process to decide and implement changes to key components
- Enrolled patients are engaged with the program and grateful for the support

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