**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. 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.\(^1\)\(^2\)\(^3\)

**Population:** UCSF patients with San Francisco Health Plan (SFHP), a managed Medcal 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%).

**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.

**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

**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**

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.

**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 for alcohol and substance use
- 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