Innovative Health Systems Approach to Achieve Health Equity in Diabetes Prevention

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Introduction

Type 2 diabetes disproportionately impacts African American and Hispanic communities. A key feature of the National Diabetes Prevention Program (National DPP), is a year-long structured, lifestyle change program, focused on healthy eating and physical activity, that can prevent or delay the onset of Type 2 diabetes.(2)

With funding from Centers for Disease Control and Prevention (CDC), and in collaboration with the American Medical Association (AMA) and Black Women’s Health Imperative (BWHI), ACPM selected three health care organizations to implement innovative strategies to screen, test and refer Black and Hispanic women with prediabetes into the National DPP.

Sites & Methodology

Through monthly calls and site visits the partners (ACPM, AMA & BWHI) provided technical assistance to three grantees below:

Northeast Valley Health Corporation (NEVHC) is a federally qualified health center in Los Angeles County serving a population that is more than 84% Hispanic/Latino. They 1) created an alert on the clinical decision support tool to identify patients to be screened; 2) developed an algorithm and educated providers on when to diagnose, counsel and refer patients; 3) referred patients to an internal National DPP and provided virtual classes during the COVID-19 pandemic 4) screened and addressed social determinants of health (SDOH ) using the PRAPARE tool and OneDegree for referrals.

Parkland Health and Hospital System (UTSW) is an integrated safety net system in Dallas County referring patients to an external National DPP at Baylor Scott & White Health. They 1) implemented population health-based screening and trained clinicians to refer patients; 2) optimized referral workflows from Parkland to Baylor. Baylor 1) reached out to referred patients to enroll in their virtual classes and 2) integrated farm stand voucher education into the National DPP classes to address food insecurity.

University of Washington Valley Medical Center (UW Valley) is a public hospital in King County, WA referring patients to an external National DPP at YMCA of Greater Seattle. They 1) implemented clinical support tools (e.g., Smartphrases) for ordering referrals & patient education; 2) evaluated barriers to enrollment among patients referred to YMCA; 3) educated providers/patients through informational videos, meetings and materials; and 4) expanded the project to all primary care clinics and implemented Plan-Do-Study-Act cycle on prediabetes care pathway.

Results

Despite the COVID-19 pandemic, all three grantees have shown modest increases in referrals of Black and Hispanic patients. However, all have faced challenges in enrollment and completion of the National DPP and in addressing social needs.

Programmatic near-term success metrics include:

NEVHC Target Referrals and Enrollment

UTSW Target Referrals and Enrollment

UW Valley Target Referrals and Enrollment

Learnings & Opportunities

Opportunities

✓ Automating referrals and best practices for race/ethnicity data collection in EHR
✓ Clinicians need better support (e.g., scripts) on warmer hand offs & addressing patients SDOH
✓ Utilizing dedicated CHWs in communities to link patients to the program
✓ Continuous assessment and addressing SDOH from referral to program completion
✓ Hiring and prompt training of coaches that reflect the participants in the National DPP
✓ Cultural competency/SDOH education of staff

Implications for future work

This quality improvement project demonstrates that health systems changes can make a difference in supporting referrals to the National DPP lifestyle change program. However, implementing solutions requires customizing the health system approach to the specific health care environment and developing/sustaining strong community partnerships.

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References


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