BlueCross BlueShield of Illinois

Eight Steps Toward Health Equity in Diabetes

Great disparities exist between groups in the U.S. around the incidence, prevalence and sequelae of diabetes. You may have seen evidence of this in your own practice.

While the problem may seem large, you can make a difference in closing the health equity gap right in your office by following these eight steps:

- Educate Yourself
- Gather Key Disparities Data for Your Patients
- Assess Your Office Culture
- Reach Out to Your Patients
- Use Evidence-based Interventions
- Ask About Social Determinants of Health
- Utilize Community Resources
- Speak Up

The typical official Healthcare Effectiveness Data and Information Set (HEDIS®) quality measure for diabetes include the percentage of people with diabetes who have their:

- A1cs tested at least annually
- A1c above 9 and under 8
- Eyes examined annually
- Feet examined annually
- Blood pressure well controlled
- Lipids checked and treated
- BMI under 30
- Dental exam completed annually
  Kidney health evaluation defined as eGFR and urine albumin-creatinine ratio annually

1. Educate Yourself
Cultural competence is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural and linguistic needs of patients.[1] Knowing this, the American Diabetes Association provides a library of diabetes resources in multiple languages to help you share information with your patients.

With an emphasis on learning about a culturally and linguistically appropriate clinical encounter, the U.S. Department of Health and Human Services offers free resources to learn more about applying the National CLAS Standards in daily work.

2. Gather Key Disparities Data for Your Patients
Race or ethnicity, sex, age, disability, socioeconomic status and geographic location all contribute to an individual's ability to achieve good health. It is important to recognize the impact that social determinants have on health outcomes of your office's patient population.

By using resources like those listed below, you may determine key disparities of your patients.

- Mapping America: Every City, Every Block
- US Census Bureau: American Fact Finder
- Kaiser's Dual Eligible Beneficiaries (by race/ethnic)

3. Assess Your Office Culture

- Make sure all patients feel welcome in your office by having your staff follow a cultural competency checklist.
- Visit the National CLAS Standards and the Communication Guide on the U.S. Department of Health and Human Services Office of Minority Health website for suggestions and training on culturally appropriate signage at the right reading level.

- Have culturally diverse reading material in the office.
- Make cultural competence an item at your monthly staff meetings.
- Make some hours and walk-in policies helpful to people with limited resources.

4. Reach Out to Your Patients
Proactive outreach is effective in closing care gaps. The registry function in the electronic medical record can be used to find patients whose last recorded A1c was over a year ago or was abnormal. Consider inviting them back for an appointment or a recheck with a nurse.

You may want to encourage your patient to call in or keep track of their blood sugar readings between visits and document.

5. Use Evidence-based Interventions
One approach you may choose is the American Diabetes Association's (ADA's) Standards of Medical Care in Diabetes, which is updated and published annually and provides the most current evidence-based recommendations for diagnosing and treating adults and children with all forms of diabetes.

Once you have a diabetes diagnoses, the Mayo Clinic offers decision aid cards and brochures in both English and Spanish that you may want to use to help explain medications and treatment plans to your patients.

6. Ask About Social Determinants of Health (SDoH)
Examples of SDoH include transportation limitations, access to healthy foods, ability to afford medication, safe and affordable housing, public safety and physical barriers, especially for people with disabilities. Providers may assess each patient's SDoH by using a list like the one on HealthyPeople.gov.

7. Utilize Community Resources
Once you've identified a SDoH for a patient, you can help your patient find a solution by using websites such as 211.org or Aunt Bertha to find community resources in their neighborhood.

Establish good two-way communication with effective community groups like the Illinois Department on Aging. See the Illinois Area Agencies Aging Map for an agency in your area. Many agencies host chronic disease self-management education classes.

8. Speak Up
Don't think your power to affect change stops at the office door. Voice your support for improvements in SDoH.

[1]Betancourt, J. R., Green, A. R., & Carrillo, J. E. 2002. Cultural competence in health care: Emerging frameworks and practical approaches. New York: The Commonwealth Fund

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