EBAN 3D Collaborative™

Defeating Diabetes Disparities

Team Name: Adult & Seniors Health and Endocrinology

Date: July 31, 2013

Aim

- Ultimate Goal
  - Improve optimal diabetes care for the African American population by 4.2%.
- Goal
  - Improve engagement of patients with diabetes through educational resources.
- Aim
  - Better utilize educational resources and services available through HealthPartners.

Team Members

Name	Title	Organization
	Community Partner	
	Community Partner	
	Community Partner	
	Community Partner	
	Physician	HP - ASH
	RN - CDS	HP – ASH
	Nurse Practitioner	HP – Endo
	RN - CDS	HP – Endo
	BSS	HP – ASH
	Dietitian	HP – ASH
	RN	HP – ASH
	CMA	HP – ASH
	Clinic Assistant	HP - Endo

Plan-Do-Study-Act (PDSA) Cycles

PDSA #1 – RN Referral to Case Management				
Test Cycle 1	Start Date 6/27/13		End Date 7/24/13	
Plan	Providers identify potential patients who would benefit from Disease & Case Management referral.			
Do	RN/CA reached out to patients and offered Disease & Case Management referral.			
Study	•Attempted to contact 20 patients. •Made contact with 14 patients. •12 of 14 patients accepted referral to Disease & Case Management. •6 of those 12 are currently engaged with Disease & Case Management. •Remaining 6 patients could not be reached by Disease & Case Management. •Overall 30% of patients we attempted to contact are engaged in Disease & Case Management.			
Act	In 1-2 months RN will follow up with patients to survey engagement with Disease & Case Management and satisfaction with program.			

Plan-Do-Study-Act (PDSA) Cycles

PDSA #1	
Objective	To use already established resources to help educate and improve overall diabetes health in the African American community.
Prediction	50% of patients will engage with Disease & Case Management.
Population	African American patients with diabetes from Adult & Seniors Health, and Endocrinology.

Next PDSA Cycle

- Determining if provider reaching out to patients increases engagement with Disease & Case Management.
- Partnering with Disease & Case Management to facilitate communication and break down barriers.

How have you integrated your community partners into your improvement work?

- Community partners agreed to survey members of their community regarding diabetes.
- Community partners are helping brainstorm ideas for future PDSA cycles.

Success & Challenges

- Success
  - 6 patients now enrolled in Disease & Case Management.
- Challenges
  - Reaching the patients
  - Communication between departments
  - Patient follow-through