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Updated 5/21/2013

EBAN 3D Collaborative™

EBAN 3D – *Clinic name*
Project Charter

Project Start Date: May 2013
Project End Date: May 2014

Case for Change:
We want all patients to be able to optimally manage their diabetes and know from our data and national data there are disparities in diabetes outcomes between patients who are white and those from communities of color. Understanding the needs of our diverse populations will allow us to better serve them by improving their diabetes care.

Project Key Stakeholders:
- Project Sponsors – Beth Averbeck, Nance McClure, and Joan Sandstrom
- Project Leaders – Dawn Barthel, Katie Kullman, Alexis Forsberg, CNP, and Matt Abeln, MD; Larisa Turin and Jennifer Hines, MD; Mary Beth Causse and Rynn Burke, MD; Larisa Turin and Mike Westerhaus, MD; and Denise Weathers, Louise Winter, DNP, and Ben Stenzler, MD
- Project Managers – Allison Johnson and Quinn Kitchen-Miller
- Community Members – Patients, caregivers and community members, Flamingo Restaurant owners, community health advocates, agencies with a vested interested in diabetes management and support
- Internal Entities – Institute for Education and Research, Medical Group, Nursing, Pharmacy, Diabetes Program, Disease and Case Management, Endocrinology, Nutrition Services, and Care Innovation & Measurement

Team Participants:
<list team members here>

Project Overview:
- Reduce the disparities between white and African American and East-African born populations.
- Educate teams involved on the quality improvement process to leverage improvement opportunities
- Ensure improvement of optimal diabetes care at Midway, Center for International Health, Adults & Seniors and Endocrinology, Riverside, and Minneapolis Clinics through an equitable health learning collaborative. Develop culturally specific recommendations and best practices to spread to other sites.
- Improve our optimal diabetes care rate for patients of color who achieve optimal health as measured by Minnesota Community Measurement specifications and internal disparity measures.
- Develop community engagement to create best practices to improve diabetes health outcomes
- Improve understanding of community resources and support systems available outside the care system

Project Scope:
- The following care teams will participate: _____
- The ____ population at the ____ Clinic
- Improvement of A1C, blood pressure, and LDL measures
- Engage community members in a dialogue to create culturally-specific best practices

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Metrics and Measures:

- Improve the blood pressure, LDL, and Hgb A1 components of optimal diabetes care rates for (population) at (location) Clinic by May 2014
    - LDL from ___% to ___%
    - Hgb A1c from ___% to ___%
    - Blood Pressure from ___% to ___%
- Reduce the rate of disparity for HPMG and PN patients with a diagnosis of diabetes
- 'Optimal Diabetes Care' is defined as the per cent of patients in the eligible diabetes population who meet the following criteria:
    - An LDL screen within the past 12 months and value ≤99
    - An A1c test within the past 12 months and value ≤7.9%
    - A blood pressure value within the past 12 months and value ≤139/≤89
    - Non smoking
    - Aspirin use if co-existing cardiovascular disease