EBAN 3D Collaborative™

Defeating Diabetes Disparities

Midway Team

Aim

To partner with African American (AA) diabetics in the Hines Care Panel to develop strategies for self-management of their diabetes and related measures for improved disease control with an emphasis on blood pressure control.

Measures and Interventions

Study period between June 1, 2013-May 19, 2014

71 (40 women; 31 men) total AA diabetics are in the Hines Care Panel.

a. Average age for both sexes-56

b. Average Body mass index (BMI)-women-34; men-31. 10 patients with BMI>=40

c. 30% with depression; 12% with other psychiatric disorder; 16%-chemically dependent

d. Tobacco abuse-59%

PDSA #1 and 2 - Basic queries to patients about their blood pressure and its importance in their diabetes care.

PDSA #3 - Development of a handout with goal setting elements (listed below) that were associated with resources to help with diabetic management and lifestyle changes.

PDSA #4 - Development of a team song and exercise video to aid those struggling with exercise.

Results

Patient numbers	Goals	Improvement	No changes
11	Dietary Changes	7	4
7	Exercise program	3	4
7	Weight reduction	5	2
6	Smoking cessation	1	4
2	Salt restriction	2	-
2	Alcohol abuse	1	1
3	Stress reduction	3	-

Comments:

a. Improvement was loosely defined as making one change in eating; starting an exercise program; having definite stress reduction strategies as part of lifestyle.

b. Many of the patients needed, on the average, 3-4 visits before goals were set and acted on.

c. Concerning blood pressure, of the 68 patients eligible during the study period, 73% became **at goal.**

Lessons Learned

1. Many patients have goals for their diabetes care, but don't often share them with their providers, so they may not feel empowered to follow through with them.
2. Trust, mutual respect and a lot of repetitive education and reinforcement about diabetes and lifestyle changes by the care team was needed to keep engagement about goals set by the patients.
3. It is important to find community programs that can partner with the medical community to give a balance approach to patient engagement, commitment and sustainability of health goals.

Recommendation for Spread

We want to use our exercise video in the exam rooms, YouTube on the Internet or on CDs that we give to patients for motivation to get into moving, no matter what level of mobility they may have. Easy demonstration of exercises that can be used in the office, home, anywhere.

Direction for Change Initiatives

- Given changing landscape in the future, where do you recommend the organization focus? Partnerships with community programs around their clinics.
- What should the organization explore further? Use of peer educators and /or community health workers that can be trained to facilitate goal setting and patient follow up.