Community Health Education
Diabetes Equity Project

Baylor Health Care System
Office of Health Equity

April 30, 2010
What is the Office of Health Equity?
BHCS Office of Health Equity

• The Office of Health Equity (OHE) was developed to reduce variation in health access, health care delivery, and health outcomes due to:
  β Race/Ethnicity
  β Age
  β Gender
  β Income and Education (i.e. SES)
  β Other personal characteristics (i.e. primary language skills)

BHCS Health Equity Triangle

The strategy of the OHE is to analyze, report, and propose solutions to decrease health disparities by working within three main Health Equity Dimensions.
How do we define Equity?

• **Equity** occurs when all individuals receive the same quality of health care within a hospital, regardless of individual characteristics such as race, ethnicity, language spoken or socioeconomic status.
  – Needs are equally met
  – Health care factors that could potentially contribute to differential patient outcomes have been minimized

• **Health Inequalities**: differences in health that are “avoidable”, “unjust” and “unfair”

Some Context!
Diabetes in Dallas, TX

• There are an estimated 202,490 diabetes cases in the Dallas Metropolitan area

• Between 2003 and 2005, the hospitalization rates for short-term complications of diabetes in Dallas County were higher than the rates for the State of Texas
  – Many Texans with diabetes have limited access to proper health care due to economic and social disparities

Care inequity in Texas cited

State health care rankings
Overall rank in 2009

<table>
<thead>
<tr>
<th>Rank</th>
<th>1-13</th>
<th>14-26</th>
<th>27-38</th>
<th>39-51</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas ranks</td>
<td>46th overall</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Top five indicators

- **Access**, which means how many have insurance:
  - Rank: 51

- **Avoidable hospital use and costs**:
  - Rank: 42

- **Healthy lives**, which is a measure not just of fitness (smoking and obesity) but also of mortality from breast cancer, colorectal cancer, suicide, etc.:
  - Rank: 21

- **Prevention and treatment**:
  - Rank: 43

- **Equity**, which means how good is your safety net:
  - Rank: 51

NOTE: Rankings include the District of Columbia
SOURCE: The Commonwealth Fund

TROY OXFORD/Staff Artist
Community Health Education
First Step!
Community Diabetes Education (CoDE™) Program

• **DESCRIPTION:** A low-cost diabetes education program for uninsured diabetics taught during one-on-one sessions between a patient and a bilingual community diabetes health promoter
  – A collaboration between Baylor Health Care System, Office of Health Equity & Central Dallas Ministries (a community social service non-profit agency)

• **PURPOSE:** Teach low-income, uninsured diabetics how to properly manage their disease to achieve target HBA1c, blood pressure, and Diabetes Quality of Life survey scores.
Community Health Education Pilot
Community Diabetes Education (CoDE™)

• Collaboration with local charity clinic:
  – 2003 - Present

• Eligibility based upon income level:
  – Family Income < 200% Federal Poverty Level

• Seven, one-on-one patient visits over 12 months with a Diabetes Health Promoter

• Over 200 uninsured patients enrolled during first 24 months
  – Currently (2008) ≈ 300 Patients enrolled
Outcomes: Community Diabetes Education (CoDE™) Pilot

Change in Hgb A1C

Community Diabetes Education (CoDE™) Program
Community Health Education
Second Step!
Community Health Education
Diabetes Equity Project

• The Big Idea!
  – Develop a comprehensive program, leveraging community partnerships, to augment private physician’s care of low-income diabetic patients.

• Three Core Components:
  – Patient Support: enhance patient education and personal empowerment
  – Provider Support: enhance cultural competencies and communication skills in diabetes care
  – System Support: create a useful Diabetes Patient Registry

• A Five Year Journey:
  – Feb 2009 – Dec 2013

• Funding:
  – $1,686,061 – Merck Company Foundation Grant
One life at a time...

• Displaced by Hurricane Katrina, a 49 year old African-American woman relocates to Dallas...
  • Diagnosed with Type 2 diabetes 7 years ago
  • Clearly depressed (recently lost job due to economy, relocated from her home, chronic disease)
  • Not engaged in diabetes self-management behaviors
  • Two recent admissions to ED and hospital with urinary tract infection and extremely high blood glucose (~600 mg/dl)
  • Primary care provided at local charity clinic for 2 years

www.alliancefordiabetes.org
She begins seeing the Diabetes Health Promoter

Over the next six months...

- **Coordination of Care**
  - DHP alerts doctor of depressive symptoms as well as diabetes related information
    - Patient starts on anti-depressant
  - Routine communication between DHP and health care team

- **Patient-Centered Care**
  - 4 hours with patient
    - 5 one-on-one visits
    - 2 phone conversations
  - Customized educational content
    - Flexible care protocol

- **Cross-Cultural Care**
  - Bilingual
  - Integrate cultural and patient-specific needs, particularly with meal planning and exercise

Her response...

- **Depression lifting**
  - Interviewed for new position
  - Takes pride in her appearance

- **Committed to her health**
  - Takes 2 buses to get to her appointments
  - Following meal plan and exercising regularly
  - Checking blood glucose
  - Following medication regimen

- **Empowered**
  - Literally jumped up and down with excitement when she learned of her latest A1C result
  - “I don’t think I could ever find such a great program anywhere else”
  - Interviewing for new jobs
Diabetes Equity Project

1st Core Component: Patient Support

- **Patients**
  - Dallas County Residents
  - >18 Yrs of age, diagnosed with Type 2 Diabetes
  - Uninsured or Underinsured (i.e. M/A; M/C)
  - All Racial & Ethnic Backgrounds
    - Target African Americans and Hispanics – higher prevalence of Diabetes

- **5 DHPs deployed in 5 community safety net clinics**
  - Baylor Family Medicine @ Worth St.
  - Central Dallas Ministries Health Clinic
  - Healing Hands Health Clinic (Lake Highlands)
  - Hope Clinic of Garland
  - Irving Interfaith Health Clinic

- **Target: 1,000 patients**
  - Enrolled over the course of 4 years
Diabetes Equity Project
Patient Support: Overview

• **Community Diabetes Health Promoters**
  – State Certified Community Health Workers (CHWs)
  – Medical Assistants
  – Trained by Ruth Collins Diabetes Center & Endocrinologist
  – Peer representative of host site’s community

• **Referral Partners**
  – Project Access Dallas (PAD)
    • Volunteer Private Practice Physicians
  – Dallas County Community Charity Clinics
  – Baylor-owned Charity Clinics
  – Community at large
    • i.e. Community Health Centers, BHCS & other Dallas County Hospitals
  – BHCS Diabetes Center
Diabetes Equity Project
The Diabetes Health Promoter Team

Magdalena, Sayra, Chris, Claudia, Miriam, Martha
Diabetes Equity Project
Patient Support: Intervention

• **Intervention Program**
  – Community Diabetes Education Program (CoDE™)
  – One-on-One format
    • Up to 7 patient contacts per year
    • Culturally competent program delivery
  – Incorporates ADA Standards of Care & AADE’s 7 Self Care Behavior Education
  – Clinical support for DHPs with Primary Care Physician & contracted Endocrinologist
Diabetes Equity Project
Patient Support: Patient-Centered Focus

**WAITING AREA**
- Think about this question... “Of all the things that could happen during this visit, what would be the most important thing?” Your DHP will be asking you this shortly.

**YOUR VISIT WITH THE DIABETES HEALTH PROMOTER**
- Answer some questions about you and your diabetes
  - Height and weight
  - Blood pressure
  - Blood glucose and A1C
  - Feet
- Check your
- Learn about
  - Diabetes
  - Healthy eating tips
  - Questions that you have
- You’ll be given
  - Information on healthy eating
  - Your diabetes daily reminder sheet
  - Updated information for your wallet card
  - Instructions and appointment for your next visit
  - Patient satisfaction survey to complete today (below)

**AFTER YOUR VISIT**
- The DHP will inform your doctor of how you are doing and how we can better assist you.

---

### How long have you been going to the Diabetes Health Promoter (DHP)?

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3 months</td>
<td>☐</td>
</tr>
<tr>
<td>At least 3 months but less than 1 year</td>
<td>☐</td>
</tr>
<tr>
<td>More than 1 year</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### Patient Satisfaction Survey

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were you treated with respect today?</td>
<td>Not at all (0)</td>
</tr>
<tr>
<td>2. During today’s visit, did you increase your understanding of diabetes care for yourself?</td>
<td>Not at all (0)</td>
</tr>
<tr>
<td>3. Do you feel that you could call the DHP to ask questions about the care of your diabetes?</td>
<td>Not at all (0)</td>
</tr>
<tr>
<td>4. How likely would you be to recommend this program to one of your friends or family members who has diabetes too?</td>
<td>Not at all (0) Very likely (4)</td>
</tr>
</tbody>
</table>

**DHP Vision**
- To provide safe, quality and compassionate health promotion...

**Patient Tools**
- Checklist
- Wallet Card
- Appropriate literature

**Frequent satisfaction assessments**
- Staff Feedback
- Staff Evaluation
Diabetes Equity Project
Patient Support: DHP Culture

• **Commitment to Training**
  – CHW State Certification (160 hour program)
    • Skill Development: Communication, Teaching, Service Coordination, Health Advocacy, etc.
    • Must obtain >90% on exam
  – Diabetes Knowledge
    • 50 hours initially (must obtain >90% on exam)
    • 18 hours continuing education/year
  – Cross-Cultural Care
    • 10 hours continuing education/year

• **Collaborative Mindset**
  – Within evidence-based protocol and MA scope of practice, DHP-driven innovation encouraged
    • Thank You notes for depressed or reticent patients
    • Hispanic based meal planning
  – Frequent communication
    • Bi-weekly team meetings
    • Bi-weekly visits by DEP Coordinator to site (monthly 1 on 1 meetings, monthly meetings with DHP and Clinic Executive Director)
    • DEP Dashboard and patient feedback reviewed with DHP team monthly
    • Monthly DEP leadership meetings
Diabetes Equity Project

2nd Core Component: Provider Support

• Use of Diabetes Patient Registry to monitor improvement (setbacks) for DEP patients
  – Patient-specific DHP visit summary reports
    • Faxed/scanned to providers after each visit
    • Real-time adjustment of patient treatment plans

• Cross-Cultural Care CME/CEU Opportunities (3/year)
  – Enhance knowledge of:
    • Health care disparities
    • Cross-cultural issues related to patient care & medical decision making – Explanatory Model
    • Effective communication of patient diagnosis & management options
Diabetes Equity Project

3rd Core Component: Health System Support

• Deploy Diabetes Patient Registry
  – DiaWeb™ Application:
    • Monitor patient participation, clinical and behavioral results of DEP
  – Accessible to all Diabetes Care Sites:
    • Data input and management by community diabetes health promoters (DHP)
  – Capabilities:
    • “Practice-level reports” (Automated quarterly)
      – Provided to clinic/physician leaders quarterly
    • “Patient-level reports”
      – Faxed and/or scanned electronically to physician
Visit Summary

Date of Birth: [Redacted]
Medical Record #: [Redacted]
Diabetes Type: Type 2

Last Visit Date: 4/15/2010
Referring Provider: [Redacted]
Program Start Date: 10/9/2009
Education Center: [Redacted]
Health Care System: Diabetes Equity Project

HgbA1c

<table>
<thead>
<tr>
<th>Percent</th>
<th>10.4</th>
<th>9.9</th>
<th>6.3</th>
</tr>
</thead>
</table>

Weight

| Pounds | 230 | 219 | 230 | 230 | 229 |

Self-Management Report Card

Medication Adherence
Glucose Monitoring
Meal Plan Adherence
Exercise Frequency

Comments: 4/15/2010
Visit 5
Spent over 30 minutes with patient reviewing meal portions, monitoring and physical activity. PT is doing a great job, she is following a meal plan, an exercise routine and she is checking her blood glucose every day. Attached please find a copy of her log book report.
BP: 100/64
BG: 93/RANDOM
A1c: 6.3
MICROALBUMIN: 20
MONOFILAMENT: GOOD

Reminders

<table>
<thead>
<tr>
<th>Due</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/15/2015</td>
<td>Pneumonia Vaccination 4/15/2010</td>
</tr>
<tr>
<td>Unknown</td>
<td>Denial Exam No Exam</td>
</tr>
<tr>
<td>Unknown</td>
<td>Foot Exam No Exam</td>
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Alerts

BMI > 25 kg/m2 (30.30 kg/m2 on 4/15/2010)
Visit Summary

Date of Birth: 
Medical Record #: 
Diabetes Type: Type 2

Last Visit Date: 4/15/2010
Referring Provider: 
Program Start Date: 10/9/2009
Education Center: 
Health Care System: Diabetes Equity Project

---

**HgbA1c**

- 10.4
- 9.9
- 6.3

- 04/09/2009
- 01/09/2010
- 04/09/2010

**Weight**

- 230
- 219
- 230
- 230
- 229

- 04/09/2009
- 01/09/2009
- 01/05/2010
- 02/28/2010
- 04/09/2010

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**Self-Management Report Card**

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<th>Rarely</th>
<th>Sometimes</th>
<th>Most of the Time</th>
<th>Always</th>
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<td></td>
<td></td>
</tr>
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<tr>
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<td>219</td>
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<td>230</td>
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</table>

Key:
- Black: Callus
- Black: Ulcer (ulcer size noted in cm)
- Red: Unable to feel monofilament
- Red: Redness
- Black: Swelling
- Black: Warmth

Self-Management Report Card

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Community Health Education
Diabetes Equity Project
Measuring Processes & Outcomes
Outcome Reporting

- **Operational Reporting (DiaWEB™)**
  - Program Reports (demographics)
  - Process Outcomes
    - Referral Reports
    - Self-Care Behavior (healthy eating, physical activity, smoking, etc.)
    - Patient Labs Due
    - Patient Management Due (i.e., annual eye exams)

- **Clinical Outcomes**
  - Hemoglobin A1c
  - Blood Pressure
  - BMI

- **Patient Satisfaction**
  - % of patients giving staff/program “Top Box” Satisfaction Score
DEP Patient Enrollment
Cumulative Total

Oct-09  | Nov-09  | Dec-09  | Jan-10  | Feb-10  | Mar-10  | Apr-10  | May-10  | Jun-10  
---|---|---|---|---|---|---|---|---
69   | 105  | 144  | 187  | 208  | 270  |         |         |        

- Cumulative Total
- Enrollment Goal
### Diabetes Equity Project

#### Overall Patient Satisfaction

**October 2009 - June 2010**

<table>
<thead>
<tr>
<th>Month</th>
<th>Patient Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-09</td>
<td>96.0%</td>
</tr>
<tr>
<td>Nov-09</td>
<td>99.5%</td>
</tr>
<tr>
<td>Dec-09</td>
<td>98.6%</td>
</tr>
<tr>
<td>Jan-10</td>
<td>99.3%</td>
</tr>
<tr>
<td>Feb-10</td>
<td>99.5%</td>
</tr>
<tr>
<td>Mar-10</td>
<td>98.6%</td>
</tr>
<tr>
<td>Apr-10</td>
<td></td>
</tr>
<tr>
<td>May-10</td>
<td></td>
</tr>
<tr>
<td>Jun-10</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>121</td>
</tr>
<tr>
<td></td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>133</td>
</tr>
<tr>
<td></td>
<td>108</td>
</tr>
<tr>
<td></td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>65</td>
</tr>
</tbody>
</table>
Diabetes Equity Project
Overall Top Box Percentage
October 2009 - June 2010

Source: Lee, F., “If Disney Ran Your Hospital, 91/2 Things you would do differently”, 2005.
# Hemoglobin A1c Outcomes Report

**Report Date:** 4/13/2010  
**Program Start Date:** 4/13/2009 and 4/13/2010  
**Program Status:** Active  
**Education Center:** All  
**Education Program:** DEP Year One; All  
**Referring Provider:**  
**Selected Time Frame:** 12 months

**Total number of patients included in outcomes report:** 99  
*Includes only the patient records which meet all of the outcomes report criteria*  
**Total number of patients excluded from the outcomes report:** 172  
**A patient record must meet the report criteria and have one Hemoglobin A1c dated on or 6 months prior to program start date and a second Hemoglobin A1c dated within the selected time frame to be included in the Hemoglobin A1c Outcomes Report.*

<table>
<thead>
<tr>
<th>HgbA1c Measure</th>
<th>A1c dated on or 6 months prior to Program Start Date</th>
<th>A1c dated within 12 months Program Start Date</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average A1c</td>
<td>8.93%</td>
<td>8.06%</td>
<td>-0.87</td>
</tr>
<tr>
<td>Number (%) of patients with HgbA1c above 9%</td>
<td>42 (42.42%)</td>
<td>27 (27.27%)</td>
<td>-55.56%</td>
</tr>
<tr>
<td>Number (%) of patients with HgbA1c below 7%</td>
<td>23 (23.23%)</td>
<td>37 (37.37%)</td>
<td>37.84%</td>
</tr>
</tbody>
</table>

**Distribution of HgbA1c Value by Range**

<table>
<thead>
<tr>
<th>Range</th>
<th>Count</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or equal to 6%</td>
<td>10</td>
<td>28.57%</td>
</tr>
<tr>
<td>Between 6.1% and 7.0%</td>
<td>15</td>
<td>42.31%</td>
</tr>
<tr>
<td>Between 7.1% and 8.0%</td>
<td>18</td>
<td>5.29%</td>
</tr>
<tr>
<td>Between 8.1% and 9.0%</td>
<td>14</td>
<td>-7.69%</td>
</tr>
<tr>
<td>Between 9.1% and 10%</td>
<td>9</td>
<td>18.18%</td>
</tr>
<tr>
<td>Greater than 10%</td>
<td>33</td>
<td>-106.25%</td>
</tr>
</tbody>
</table>
# Blood Pressure Outcomes Report

**Report Date:** 4/21/2010  
**Program Start Date:** 4/21/2009 and 4/21/2010  
**Program Status:** Active  
**Education Center:** All  
**Education Program:** DEP Year One;  
**Referring Provider:** All  
**Selected Time Frame:** 12 months

---

**Total number of patients included in outcomes report:** 212  
*Includes only the patient records which meet all of the outcomes report criteria*

**Total number of patients excluded from the outcomes report:** 73  
*Includes only the patient records which meet all of the outcomes report criteria*

**A patient record must meet the report criteria and have one Blood Pressure dated on or 6 months prior to program start date and a second Blood Pressure dated within the selected time frame to be included in the Blood Pressure Outcomes Report.**

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Blood Pressure dated on or 6 months prior to Program Start Date</th>
<th>Blood Pressure dated Within 12 Months of Program Start Date</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Systolic</td>
<td>129.59 mmHg</td>
<td>127.36 mmHg</td>
<td>-2%</td>
</tr>
<tr>
<td>Average Diastolic</td>
<td>77.45 mmHg</td>
<td>76.6 mmHg</td>
<td>-1%</td>
</tr>
</tbody>
</table>

| Number (%) of patient with BP less than 130/80 mmHg | 144 (67.92%) | 147 (69.34%) | 2.04% |

<table>
<thead>
<tr>
<th>BP Distribution (mmHg) by Number (%)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic less than 120/ Diastolic less than 80</td>
<td>48 (22.64%)</td>
</tr>
<tr>
<td>Systolic 120 to 139/ Diastolic 80 to 89</td>
<td>93 (43.87%)</td>
</tr>
<tr>
<td>Systolic 140 to 159/ Diastolic 90 to 99</td>
<td>57 (26.89%)</td>
</tr>
<tr>
<td>Systolic greater than or equal to 160/ Diastolic greater than or equal to 100</td>
<td>14 (6.6%)</td>
</tr>
</tbody>
</table>
# Weight/BMI Outcomes Report

Report Date: 4/21/2010  
Program Start Date: 4/21/2009 and 4/21/2010  
Program Status: Active  
Education Center: All  
Education Program: DEP Year One;  
Referring Provider: All  
Selected Time Frame: 12 months  

Total number of patients included in outcomes report: 213  
*includes only the patient records which meet all of the outcomes report criteria  
Total number of patients excluded from the outcomes report: 72  
**A patient record must meet the report criteria and have one Weight/BMI dated on or 6 months prior to program start date and a second Weight/BMI dated within the selected time frame to be included in the Weight/BMI Outcomes Report.  

| Weight               | Weight / BMI dated on or 6 months prior to Program Start Date | Weight / BMI dated within 12 months of Program Start Date | Change  
|----------------------|---------------------------------------------------------------|----------------------------------------------------------|---------  
| Average Weight       | 192.44 lbs                                                   | 191.5 lbs                                                | -0.94    
| Average BMI          | 33.16                                                        | 32.99                                                    | -0.52%  
| Number (% of patients with BMI greater than 25) | 193 (90.61%)                                                | 193 (90.61%)                                             | 0%      
| Number (% of patients with BMI less than or equal to 25) | 193 (90.61%)                                                | 193 (90.61%)                                             | 0%      
| Number (% of patients with BMI less than or equal to 25) | 20 (9.39%)                                                  | 20 (9.39%)                                               | 0%      |
# Glucose Monitoring Outcomes Report

**Report Date:** 4/21/2010  
**Program Start Date:** 4/21/2009 and 4/21/2010  
**Program Status:** Active  
**Education Center:** All  
**Education Program:** DEP Year One;  
**Referring Provider:** All  
**Selected Time Frame:** 6 months  

Total number of patients included in outcomes report*: 182  
*includes only the patient records which meet all of the outcomes report criteria  
Total number of patients excluded from the outcomes report**: 103  
**A patient record must meet the report criteria and have one Glucose Monitoring dated on or 6 months prior to program start date and a second Glucose Monitoring dated within the selected time frame to be included in the Glucose Monitoring Outcomes Report.  

<table>
<thead>
<tr>
<th>Self Monitoring Blood Glucose</th>
<th>Assessment dated on or 6 months prior to Program Start Date</th>
<th>Assessment dated Within 6 Months of Program Start Date</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (%) of patient who self-monitor blood glucose</td>
<td>125 (68.68%)</td>
<td>177 (97.25%)</td>
<td>29.38%</td>
</tr>
<tr>
<td>Number (%) of patient who do not self-monitor blood glucose</td>
<td>57 (31.32%)</td>
<td>5 (2.75%)</td>
<td>-1040%</td>
</tr>
</tbody>
</table>

**Frequency**  
<table>
<thead>
<tr>
<th>Frequency</th>
<th>Assessment dated on or 6 months prior to Program Start Date</th>
<th>Assessment dated Within 6 Months of Program Start Date</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Documented</td>
<td>62 (34.07%)</td>
<td>11 (6.04%)</td>
<td>-463.64%</td>
</tr>
<tr>
<td>Rarely</td>
<td>3 (1.65%)</td>
<td>5 (2.75%)</td>
<td>40%</td>
</tr>
<tr>
<td>Occasionally</td>
<td>6 (3.3%)</td>
<td>17 (9.34%)</td>
<td>64.71%</td>
</tr>
<tr>
<td>Every other day</td>
<td>11 (6.04%)</td>
<td>10 (5.49%)</td>
<td>-10%</td>
</tr>
<tr>
<td>1x per day</td>
<td>53 (29.12%)</td>
<td>72 (39.56%)</td>
<td>26.38%</td>
</tr>
<tr>
<td>2x per day</td>
<td>42 (23.08%)</td>
<td>60 (32.97%)</td>
<td>30%</td>
</tr>
<tr>
<td>3x per day</td>
<td>2 (1.1%)</td>
<td>7 (3.85%)</td>
<td>71.43%</td>
</tr>
<tr>
<td>4x per day</td>
<td>2 (1.1%)</td>
<td>0</td>
<td>-100%</td>
</tr>
</tbody>
</table>
Self-Foot Care Outcomes Report

**Report Date:** 4/21/2010
**Program Start Date:** 4/21/2009 and 4/21/2010
**Program Status:** Active
**Education Center:** All
**Education Program:** DEP Year One;
**Referring Provider:** All
**Selected Time Frame:** 12 months

**Total number of patients included in outcomes report**: 159
*Includes only the patient records which meet all of the outcomes report criteria*

**Total number of patients excluded from the outcomes report**: 126
*Includes only the patient records which meet all of the outcomes report criteria*

A patient record must meet the report criteria and have one Self-Foot Care Assessment dated on or 6 months prior to program start date and a second Self-Foot Care Assessment dated within the selected time frame to be included in the Self-Foot Care Assessment Outcomes Report.

<table>
<thead>
<tr>
<th>Self Foot Exam</th>
<th>Assessment dated on or 6 months prior to Program Start Date</th>
<th>Assessment dated Within 12 Months of Program Start Date</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (%) of patient who perform self-foot exams</td>
<td>112 (70.44%)</td>
<td>156 (98.11%)</td>
<td>28.21%</td>
</tr>
<tr>
<td>Number (%) of patient who do not perform self-foot exams</td>
<td>47 (29.56%)</td>
<td>3 (1.89%)</td>
<td>-1466.67%</td>
</tr>
</tbody>
</table>

**Frequency**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Assessment dated on or 6 months prior to Program Start Date</th>
<th>Assessment dated Within 12 Months of Program Start Date</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Documented</td>
<td>48 (30.19%)</td>
<td>4 (2.52%)</td>
<td>-1100%</td>
</tr>
<tr>
<td>Rarely</td>
<td>4 (2.52%)</td>
<td>1 (0.63%)</td>
<td>-300%</td>
</tr>
<tr>
<td>Occasionally</td>
<td>29 (18.24%)</td>
<td>27 (16.98%)</td>
<td>-7.41%</td>
</tr>
<tr>
<td>Every other day</td>
<td>8 (5.03%)</td>
<td>11 (6.92%)</td>
<td>27.27%</td>
</tr>
</tbody>
</table>
Benchmark Results* Commercial: 56.5%, Medicaid: 52.8%

# Community Health Education

## Diabetes Equity Project

### Year Two Budget

<table>
<thead>
<tr>
<th>Category</th>
<th>Year Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel (5 DHPs + Mgr.)</td>
<td>$270,000</td>
</tr>
<tr>
<td>Consultants (Endocrinology, Evaluation)</td>
<td>$15,000</td>
</tr>
<tr>
<td>Supplies/Equipment</td>
<td>$47,000</td>
</tr>
<tr>
<td>Training/Education (Personnel and CME)</td>
<td>$25,000</td>
</tr>
<tr>
<td>Office Space (In Kind)</td>
<td>$20,000</td>
</tr>
<tr>
<td>Retinal Screening ($16,500 In Kind)</td>
<td>$33,000 (250 patients)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$410,000</strong></td>
</tr>
</tbody>
</table>

$410/patient/year
Community Health Education
Diabetes Equity Project
Summary

• Diabetes Equity Project
  – “Game changing” support to private physicians & low-income diabetic patients
  – Five year funding to multiply (4X) a currently successful program
  – Augmentation of existing community charity clinic infrastructure with diabetes care support
  – Increase awareness of health care quality improvement through Diabetes disparity reduction
For More Information:

Jim Walton DO, MBA
Vice President & Chief Health Equity Officer
jameswa@baylorhealth.edu