

**EMPOWERING MY COMMUNITY: HEALTH FAIR AND SYMPOSIUM ON
CULTURALLY TAILORED DIABETES EDUCATION FOR AFRICAN AMERICANS**

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DEDICATION

This comprehensive project is dedicated to my aunt and every African American patient I encountered throughout my career as a social worker who has experienced and died from diabetes complications. I would also like to acknowledge my loving family, friends, and those who supported me during this DSW journey and became part of my tribe, agreeing to participate in this study.

I hope that this project inspires you to feel empowered to speak up and let your voice be heard. You are your best advocate for making informed decisions about your diabetes health and overall well-being. Get involved with your treatment plan and ask your healthcare provider to refer you to a dietician and a diabetes class. Do not be afraid to ask for a healthcare provider who represents you and can provide culturally tailored diabetes education.

To my husband, the king of our home, I thank you for your unconditional love and support throughout my doctoral journey. You had faith in me when my faith wavered. I could not have made it this far without your encouragement, prayers, and belief in me. Also, thank you for helping with the grandchildren and ensuring all our needs were met. Most importantly, thank you for loving me and understanding the assignment. You were my sounding board and believed my research would one day affect the African American community.

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support meant a lot to me. Your creative eye and sense of style turn everything into something spectacular! You were my editor, format queen, confidence booster, and visual genius. Thank you for having faith in me.

Last, thank you to my baby brother, EJ, for allowing me to love you and for sharing your journey when you were diagnosed with Stage IV cancer in April 2022. This was devastating news to our family, but we got through it with God's love. I took a step back from the DSW program to focus on family, and it was your positive attitude and tenacity I admired the most while you were undergoing chemotherapy and radiation. It reminded me not to sweat the small stuff and think about all that God has blessed us with. You stayed strong, and God granted us with a miracle. You are now cancer-free; you have made substantial lifestyle changes, and you are the best version of yourself. You turned 50 this year, and I look forward to 50 more years with you. God did that! He is a God of love and purpose and does not make mistakes. If we keep Him first in everything we do, He will bless us tremendously.

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Last, I thank my Lord and Savior, Jesus Christ, for giving me a vision and planting the seed to do the work and watch it manifest. “I can do all things through Christ who strengthens me” (New King James Version Bible, 2023, Philippians 4:13).

ABSTRACT

EMPOWERING MY COMMUNITY: HEALTH FAIR AND SYMPOSIUM ON CULTURALLY TAILORED DIABETES EDUCATION FOR AFRICAN AMERICANS

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The lack of culturally tailored diabetes education for African Americans is the social problem addressed in this project. African Americans accounted for 4.9 million diagnosed cases of type 2 diabetes in 2021. Type 2 diabetes and related complications are disproportionately higher among African Americans, who are twice as likely to experience complications and death than Whites. This project used empowerment theory and the socioecological model of health to support the need for culturally tailored education on diabetes. A community engagement and collaborative approach with stakeholders, community members, and an expert healthcare panel confirmed a lack of culturally tailored diabetes education for African Americans, which led to the innovation of a health fair and symposium. A scoping review conducted a year prior emphasized the lack of literature on culturally tailored diabetes education, thus revealing the need and highlighting a collaborative approach with a faith-based organization as the best choice to address this challenge. An exploratory study of diabetes also informed the health fair and symposium on culturally tailored diabetes education. The social innovation described in this project aims to raise awareness of and increase knowledge on diabetes self-management to improve health outcomes through a collaborative approach directed by the Community Engagement and Social Innovation Model. The health fair provided screenings that informed individuals of their diabetes status, and the symposium increased knowledge and understanding of diabetes. Thus, increasing local partnerships and replicating this innovation would provide additional information on the

efficacy of this innovation and its ability to effect change among African Americans with diabetes.

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EXECUTIVE SUMMARY

Empowering My Community: Health Fair and Symposium on Culturally Tailored Diabetes Education (or EMC, for short) for African Americans is the result of more than 3 decades of professional observation while working in the field of social work in various capacities, mainly as a medical social worker with African American patients with diabetes. It is also a result of firsthand family experience regarding the prevalence of this chronic disease, which is a life-altering diagnosis. The lack of diabetes education offered to African Americans drove this innovative project to address the critical need for culturally tailored diabetes education for African Americans.

The social problem identified is the lack of culturally tailored diabetes education. The number of type 2 diabetes cases is growing exponentially among African Americans. Health disparities in areas such as race, ethnicity, access to care, and quality of care, paired with discrimination, cultural beliefs, implicit bias, diabetes stigma, and medical mistrust are all factors that affect African Americans with diabetes. The identification of this problem and gaps in the literature highlight the need to address the lack of culturally tailored diabetes education to promote better health outcomes for African Americans with diabetes.

The lack of culturally tailored diabetes education is associated with two Grand Challenges for Social Work: close the health gap and eliminate racism. Examples of activities that would help close the health gap include advancing community empowerment and advocacy for sustainable health solutions, cultivating health innovations, and promoting access to healthcare. Examples of activities to eliminate racism include social work practitioners and researchers coming together to eradicate racist policies, bias, and discriminatory practices and to focus on evidence and practice-based interventions.

The integration of theology and theory helps explain the significance of this social problem and potential solutions for African Americans. Spirituality is a fundamental aspect of African American culture. It plays a significant role in this population's health belief system, practices, and health outcomes. The theoretical framework employed in this innovation project includes empowerment theory and the socioecological model of health. The empowerment theory, paired with the socioecological model of health, supports the need for culturally tailored diabetes education to enhance self-management behaviors and promote better health outcomes for African Americans with diabetes.

Great Shepherd Missionary Baptist Church in Los Angeles, located in an underserved area, was the primary stakeholder and provided a venue for this innovation project. The congregation members and other individuals from the community were the direct beneficiaries of the innovation. An expert panel of healthcare providers was also involved in this project. This engagement allowed for a shared understanding of gaps in healthcare about diabetes education for African Americans and promoted collaboration and shared ideas for this innovation.

A scoping review conducted a year ago of educational programs offered in the Black Church for African Americans experiencing diabetes identified only eight peer-reviewed articles that met the inclusion criteria during the 10-year search period. Each study used a collaborative approach and community engagement strategies by collaborating with a faith-based organization as the primary stakeholder. The review results confirmed the lack of and need for culturally tailored diabetes education for African Americans.

EMC is an innovation that addresses this social problem. It is a platform designed for an all-Black expert panel of healthcare providers to provide culturally tailored diabetes education to African Americans. Knowledge, skills, and resources to make informed health decisions are

emphasized to empower individuals to take control of their health and better manage their diabetes. Offering culturally tailored education aims to promote better health outcomes for African Americans with diabetes.

Data from an exploratory study using information gathered from interviews and questionnaires were used to assess the effectiveness of the symposium. Pretest and posttest survey results were used to evaluate the outcome and determine whether the symposium's goals were met. The symposium generated an interactive exchange between the panelists and participants, providing tools of empowerment that enabled participants to be their best advocate and manage diabetes better. The pretest and posttest analysis results revealed a 27% increase in knowledge and understanding of diabetes. All participants agreed that there is a need for culturally tailored diabetes education, especially regarding diet.

One participant had dangerously high blood pressure. The on-site physicians urged him to seek immediate medical attention, but he declined. However, the following Sunday, he testified in front of the congregation that he went to the doctor two days later and was admitted to the hospital for malignant hypertension. He told the attendees that the health fair saved his life. He acknowledged and thanked the church for the invitation to the event and hoped more events like this would occur in the future because they are needed in the Black community.

Practice recommendations include the development of partnerships between EMC and local Black churches in underserved areas of California's Inland Empire (Riverside and San Bernardino counties) to increase awareness of the number of diabetes cases affecting the Black community. EMC's objective is to raise awareness and increase knowledge on diabetes self-management to improve health outcomes for African Americans. EMC's expanded marketing plan includes offering a do-it-yourself option using the EMC planning manual to guide churches in

organizing and implementing an EMC event. Other options include churches contracting for consultant services to assist in the planning process and for onsite coordinator services on the event day.

In conclusion, EMC was influenced by professional and firsthand experiences. Due to the growing number of diabetes cases among African Americans, this innovative project was executed using the Community Engagement Social Innovation Model (CESI) created by Dr. Krystal Hays, Dr. Charles Lee-Johnson, and Dr. Antonio Mejico. This eight-phase model advances social work research and innovative practices across various settings, focusing on serving historically marginalized populations. It enables collaboration with organizations locally and globally to enhance innovative and sustainable practices that promote communities' health and collective well-being. EMC embodies the CESI model as an innovative project with the potential to have a tangible impact on improving health outcomes for African Americans.

CHAPTER 1: OBSERVATION

Observation is the first phase of the CESI Model, which involves personal and professional experiences that lead to awareness of social problems. My career as a social worker encompasses 32 years of service, of which 23 have been a medical social worker and 5 as a social work manager in an acute setting. For 4 years, I worked as a psychiatric social worker, of which 2 years were in an outpatient clinic with adults and 2 years were in a residential care setting with youth. Throughout my career, I also worked as a contractor for various organizations, serving as a home health social worker, hospice social worker, and mental health therapist at a group home for adolescent boys.

In 2023, I started an LLC, and now I am the sole proprietor of Social Work Practitioners Place, a consultancy agency. One arm of service involves collaborating with faith-based organizations, specifically the Black Church, to bring Empowering My Community: Health Fair and Symposium on Culturally Tailored Diabetes Education (EMC) to the church and surrounding community.

Professional Observation

This chapter highlights my professional and firsthand experiences and observations in the healthcare setting regarding the lack of preventive education offered for individuals diagnosed with prediabetes and the lack of culturally tailored diabetes education for African Americans who have diabetes.

Medical Social Worker: Diabetes Team Care Clinic

As a medical social worker, I was assigned to cover the Diabetes Team Care Clinic (DTCC), a multidisciplinary team composed of an endocrinologist, diabetes nurse educator, registered dietician, pharmacist, podiatrist, social worker, and licensed vocational nurse. The

DTCC provided a team approach to helping patients with a blood sugar level (known as A1C) of 9% or higher to manage their diabetes better and achieve an A1C of less than 7%. Each discipline possessed specialized training to help individuals obtain knowledge and decision-making skills vital for effective self-care.

The endocrinologist plays a crucial role in managing hormonal imbalances such as diabetes. They collaborated with the DTCC members on treatment approaches and sometimes served as the primary care physician overseeing diabetes care. The diabetes nurse educator provided education on diabetes management while coordinating care with the DTCC providers, primary care physicians, and other service providers. The registered dietician provided standardized dietary information on diabetes to all patients, regardless of race and ethnicity. The pharmacist reviewed and managed medications, the podiatrist managed foot health, the social worker assessed and assisted with psychosocial needs and addressed the behavioral aspects of living with diabetes, and the licensed vocational nurse scheduled patients for the DTCC and sent appointment letters.

While seeing patients as a member of the DTCC, I observed African Americans who developed diabetes stigma due to encountering implicit bias and racial discrimination by the diabetes nurse educator, a registered nurse certified in diabetes education. These encounters also led to medical mistrust, which affected the health outcomes of these African American patients.

During a team conference, I mentioned that I had observed a pattern in which African American patients received different treatment than White patients, and the response was that African American patients did not adhere to the treatment plan, primarily related to diet. The diabetes nurse educator reported that African Americans “eat too many bad foods such as fried chicken and macaroni and cheese.” I then highlighted that other racial groups with diabetes also

consume fried chicken and macaroni and cheese. I asked her, “Does that make them nonadherent to the diet?” The room went silent, and she never answered my question.

It is essential to mention that I was the only African American healthcare provider on the team and the only one who appeared to advocate for this group. So, I began inquiring if the dietician could create a handout or resource that included recipes for preparing healthy soul food options. I was shocked by the response I heard from the diabetes nurse educator that “all diabetic patients are given the same handouts, and if they adhered to the diet, they [referencing African American patients] would achieve better blood sugar control.” I expected the dietician to answer my question because this was her area of expertise. However, there was no consideration of or forethought as to why the African American patients in our clinic had difficulty achieving optimal glycemic control or often skipped clinic visits.

Historically, the practice at my place of employment was to refer diabetic patients with an A1C of 9% or greater to the DTCC. A1C is a blood test that shows the average blood sugar (glucose) level for the past 2 to 3 months. The only other education offered for people with diabetes at that time was a 2-hour course for people with a new diabetes diagnosis and a refresher course at the 5-year mark. Currently, at my organization [the same employer], Living Well with Diabetes is a 4-session class (2 hours each session) offered for individuals with type 2 diabetes.

Session 1 is an introduction to diabetes, nutrition balance, the plate method, and SMART goals; Session 2 is about meal planning, reading food labels, learning to monitor glucose, hemoglobin A1C, and physical activity; Session 3 is about medications, shopping and dining out, hypoglycemic control, and reducing long term risks; and Session 4 focuses on problem-solving, heart-healthy eating, healthy coping skills, sleep, stress reduction and evaluating the data.

During my tenure as a social worker in the DTCC, I observed several incidents of racial discrimination, which led to the lack of diabetes education for African Americans. The most offensive encounter again involved the diabetes nurse educator; she judged a Black male patient because he refused to stop smoking and eating soul food. The patient informed the nurse that he tried to stop smoking on several occasions but had been unsuccessful. The patient also told her that he likes flavor in his food, so unless she could provide diabetes-friendly recipes for soul food, he could not change the way he had been eating for more than 60 years overnight.

During my visit with the patient and his wife, they complained that the diabetes nurse educator told him he might as well stop coming to the DTCC because the team could not help him. After the clinic, the diabetes nurse educator made a derogatory comment during the team meeting, stating, “These people are impossible to deal with when it comes to their diet.”

When I entered the exam room, I encountered an African American patient and his wife who appeared well-educated and understood the consequences of diabetes but did not appreciate being disrespected and dismissed by the diabetes nurse educator. They told me they came to the appointment to learn more about better managing his diabetes.

When I asked the diabetes nurse educator to be more specific about her comment, she explained that African American patients are unwilling to change their diet and that this patient was rude and not willing to listen. I then asked, “How was he rude?” She relayed that he used profanity, turning to his wife and whispering, “This damn nurse is crazy if she thinks I am going to give up soul food and smoking.” I attempted to understand the exchange between her and the patient, pointing out that she spoke to him like a child, talking down to him. She also ignored his wife, who was also in the exam room, and never asked for her input even though she prepared his meals.

I also learned that the nurse educator did not provide any solutions, offer additional resources such as information or a referral to a smoking cessation class, or refer the patient to the preventive medicine department to learn about meal prep. Although there were no options for soul food, he and his wife could have learned diverse ways to prepare food in a live class, enabling them to choose healthier options and better manage his diabetes. Once the diabetes nurse educator had thoroughly berated this patient and his wife, I emphasized that all patients should be treated equally and offered resources to manage their diabetes better, regardless of their response.

I informed the nurse and the team that this was a recurring theme with African American patients seen in our clinic and that not all African American patients are nonadherent to treatment. I also reminded them that the clinic's goal was to help all patients with an A1C higher than 9% to manage their diabetes better, regardless of racial background. After this exchange, the diabetes nurse educator apologized. I pointed out that no patient and their family should ever be treated in this manner based on her personal beliefs or biases about African American patients.

Because of the negative encounters experienced by African American patients, I suggested that the DTCC create culturally tailored resources about diet to increase African American participation in the clinic and promote better health outcomes. I volunteered to spearhead this project, but the diabetes nurse educator responded that resources were standardized across the region, and no other DTCC provided alternative resources. Her final remark was, "We don't have time to create new resources," indicating that she would not support me in this endeavor or allow me time to create this new resource.

At this point, my suggestion was ignored because no one dared to challenge her because of her position and investment in the DTCC. For a few weeks, I observed slight improvement in

her demeanor toward African American patients, but she gradually resumed her usual practice, tinged by her personal biases and attitude. From this point on, I incorporated psychoeducation that included informing all African American patients about the right to be treated with courtesy and respect by their healthcare providers without discrimination based on their race. I also included the telephone number of member services so patients could file a formal complaint regarding instances that harmed their mental well-being. A couple of years later, the diabetes nurse educator resigned. It had been challenging to continue working with her, but I refused to quit because I was the only voice advocating for African American patients in our clinic.

Initially, when I learned of her resignation, I was relieved and overjoyed for all African American patients who were subjected to her racial discrimination and personal biases. But then I felt disappointed in my employer for not taking the proper action to ensure this population was not harmed in her care. As a social worker, I was their advocate and tried to create an avenue for social justice to prevail. Her resignation was, in some way, a form of social justice.

Home Health Social Worker

In the early 1990s, I became a contract social worker for a private home health agency in addition to my full-time job. I was the first African American social worker at both jobs. More than half of my home health patients were African Americans, overweight, and newly diagnosed with type 2 diabetes. The standard course of treatment by the primary care physician was to prescribe a drug called metformin, which controls and lowers high blood sugar levels and improves how the body responds to insulin. Metformin is also known to reduce deaths due to cardiovascular disease, and it sometimes helps diabetic patients lose weight.

I received multiple complaints from African American patients who reported a lack of diabetes education and that they felt like guinea pigs in an experiment while taking Glucophage

(the brand name version of metformin). The top complaint with this medication was gastrointestinal tract issues—diarrhea, to be specific. The patients reported that they informed the physicians and their primary response was, “Give the medication time to work.” This response left patients feeling their complaints about the side effects were ignored, with no consideration of reducing the dosage or prescribing other medications.

The private home health patients revealed that they only received verbal instructions during an office visit focused on lifestyle changes, such as incorporating exercise and a healthy diet, with no tools or referral to a registered dietician. When I received a referral to see patients with type 2 diabetes, the insinuation often was to complete a psychosocial assessment and “fix” the patient’s noncompliance (now called nonadherence) to the treatment plan because they must have a “death wish.” There was no consideration of the lack of diabetes education, contributing to their non-compliance. During a multidisciplinary team meeting, I suggested hiring a certified registered dietician specializing in diabetes to help patients better manage their diabetes through diet. The agency never hired a dietician; thus, African American patients continued to suffer due to a lack of education.

Hospice Social Worker

As a contracted hospice social worker for a private agency from 2015 to 2018, I provided grief counseling in preparation for the death of a loved one. This type of therapy allowed for a safe and supportive environment for patients and families to process emotions and develop good coping strategies. Similar to my time with the home health agency in the 90s, the hospice team lacked a certified registered dietician. In treating African American patients with diabetes, I observed less concern about providing education to hospice patients due to the nature of their illness. The common theme was to allow patients to eat whatever they wanted in their last days.

However, for those patients who had been on hospice services for years, the idea of allowing them to eat whatever they wanted did not make sense. As an advocate for African American patients with diabetes, I sought to provide resources that could benefit patients and their families. I often shared a personal resource, an African American certified nutritionist in the community who had changed the trajectory of my health status. Patients could relate to and trust this person, who fostered their receptiveness to being educated on organic, plant-based, vegetarian, and vegan options that could potentially slow the progression of the disease or prevent future diabetes complications.

Social Work Manager

In 2016, I took a leap of faith, left my long-time employer, and transitioned into a management position overseeing two hospitals. I saw this as an opportunity of a lifetime that would allow me to train, educate, and share my robust experience with social workers and other professionals under my supervision. Little did I know I was in for a rude awakening.

While serving as the social work manager for 2 years and interim director of case management at one site for 9 months, I witnessed countless occasions in which African American patients received substandard care, especially in the emergency room (ER). They were often discharged after hours with no referral to social services. These patients frequently returned to the ER during the day, and when my staff saw them, they would report that their reason for coming back was due to a lack of community and financial resources for follow-up care.

Most of these patients were underinsured, did not have a primary care physician or assigned pharmacy, and needed diabetes supplies and had no means to purchase them. They received a prescription and were discharged. When I consulted the ER managers at both hospitals, the typical response for the discharge was that “we needed the bed for another patient.”

Patients who needed a face-to-face meeting with a social worker sat in the waiting room or returned another day.

This practice in the ER highlighted the need to improve the workflow and create a much-needed community resource manual. I was a new manager, and this was the perfect project. My employer used the Six Sigma methodology, a data-driven approach to quality improvement, also known as lean thinking. As a social worker, I always believed that the resources provided were only as good as the source. In this case, the source was my staff, who could benefit from education on local resources in both San Bernardino and Riverside counties.

My first task was to improve the workflow at the hospital, which only had eight ER beds. I piloted an after-hours schedule for social workers to provide daily coverage from 4:30 p.m. to 8 a.m. by phone or in person if required. This pilot project proved successful after a 90-day trial period, indicated by a reduced readmission rate to the ER after hours among patients discharged without a referral to social services. The pilot project became a permanent schedule.

To continue the lean project, my first task was creating a comprehensive community resource manual covering San Bernardino and Riverside counties for both hospitals. I reviewed the current resources being used by my staff and learned that more than a third were outdated or no longer in existence and were limited to one county.

My lean project team consisted of me, my social work intern, a staff member from medical records, and a community partner. After my initial review of current resources, I assigned each team member a specific task: ensuring current resource information, developing a community resource guide, categorizing services into sections, and formatting the guide. The finished product was a comprehensive manual to improve referral to needed community resources in both counties.

In 2018, I accepted a management position at another hospital in which I observed several incidents of implicit bias, racial discrimination, and stigma against African Americans who were treated in the ER by healthcare providers, specifically physicians. If they were loud, they were labeled as mentally ill or violent, those with tattoos were assumed to be gang members, those who complained of pain were labeled as drug seekers, and those who came in with a blood sugar out of range were labeled as nonadherent diabetic patients.

During the coronavirus pandemic, these incidents increased dramatically, affecting the quality of care. If the physician felt threatened by the mere appearance of a patient, they would immediately call security or discharge the patient home or back to the streets. If the patient had diabetes, and presented with a blood sugar out of range, they were generally discharged with the directive to follow up with their primary care physician once they could lower their blood sugar, instead of admitting them or referring them to social services to ensure they were adequately linked to community resources.

When I inquired about this practice, the standard answer was always, “Because we need the bed.” For patients seen after hours, they, too, were discharged with no referral to social services or linked to community resources. Some patients were told to wait in the waiting room and see a social worker the following day. African American patients who chose to wait often complained of not being offered any food, water, or even a blanket. In these instances, I had to contact the ER and tell them to register the patient again before my staff could legally see them. This caused a major upset with the administration. Still, I quickly reminded them that unfair treatment of marginalized patients is unethical, and it was our duty to treat each patient with respect and dignity regardless of their ethnicity, race, or ability to pay for services.

The treatment of African American patients was very troubling to me, so I began to educate the ER staff and physicians during grand rounds and new resident orientation on the criteria for referring patients to social services so they can be linked to the proper resources prior to discharge to prevent readmission to the ER or hospital.

I replicated the comprehensive resource manual created at my previous job and added additional resources. This manual was uploaded to a shared online drive for case management and became a living document. Whenever a resource was updated or added, the program alerted the designated staff member and me to make the necessary changes to the manual.

It was imperative to educate my social work staff on the importance of linking patients to needed community resources, particularly those addressing chronic illnesses such as diabetes. The purpose was to prevent readmission to the hospital and potentially prevent future complications. Overall, looking back on the various positions I held, African American patients with diabetes consistently complained about their encounters with stigma, implicit bias, lack of physician representation, and most importantly, lack of education—specifically, culturally tailored education on managing diabetes.

Personal Observation and Experience

My tenure as a social work manager in case management for two large healthcare organizations from 2016 to 2021 was a pivotal time for me. It was my dream job as a leader with an opportunity to use my knowledge and experience to change the face of medical social work and the delivery of resources. In 2016, I was also diagnosed with prediabetes by a non-Black physician who only provided verbal instructions during an office visit with the directive to lose weight, change my eating habits, and incorporate exercise three to five times a week for 30 to 60 minutes each. They provided no referral to a dietician or diabetes class to ensure further

education. All I received to memorialize that day was an after-visit summary outlining those verbal instructions.

After my visit, I began to reflect on my family history and realized the only person who had diabetes was an aunt. She was diagnosed with type 2 diabetes later in life and suffered from multiple complications (i.e., stroke, lower limb amputation, and kidney failure) that took a toll on her health. After having a massive stroke, she was placed in a skilled nursing facility, where she died.

After being diagnosed with diabetes, she experienced diabetes stigma from her healthcare providers pertaining to her weight. She was told to stop eating fried chicken and macaroni and cheese to lose weight and improve her glycemic control. She was humiliated and felt ashamed, so she stayed silent. My aunt was a victim of implicit bias, stereotyping, and racial discrimination. There was no referral to a dietician or a diabetes class, and she was left to navigate these changes independently and was unsuccessful.

Conclusion

I often think about my aunt, who was diagnosed with diabetes in her 40s, and the complications she experienced due to the lack of diabetes education all leading to her premature death. My diagnosis and my aunt's death prompted me to advocate for myself and other African Americans who experience diabetes stigma, implicit bias, and racial discrimination by healthcare providers who do not understand the lived experience and mistrust of the healthcare profession among Black people.

The next chapter will highlight the prevalence of type 2 diabetes in the United States and globally, the consequences, historical factors, medical mistrust, lack of African American physicians and the social work grand challenges that are associated with type 2 diabetes.

CHAPTER 2: IDENTIFICATION

Identification is the second phase of the CESI Model that addresses the specific social problem and marginalized population impacted by the problem.

Social Problem

The social problem identified in this research project is the lack of culturally tailored diabetes education for African Americans. In 2015, an estimated less than 50% of African Americans with diabetes received diabetes education in a healthcare setting, whereas those diagnosed with prediabetes received far less due to the limited reimbursement rates for diabetes prevention (Lew et al., 2015).

In the African American community, conventional diabetes education that includes knowledge of recommended dietary changes has been pursued but unsuccessful (Sumlin and Brown, 2017). Few studies have addressed culturally tailored diabetes education in healthcare, particularly in a community-based setting.

Diabetes Statistics, Complications, and Consequences

According to the Centers for Disease Control and Prevention (2023), diabetes is a chronic health condition and the eighth leading cause of death in the United States. According to the American Diabetes Association (2023), diabetes is the fifth leading cause of death for African Americans.

The prevalence of type 2 diabetes and related complications among African Americans is growing exponentially (CDC, 2023; Office of Minority Health, 2023). Profound racial and ethnic disparities are associated with morbidity and mortality related to type 2 diabetes (Cunningham et al., 2018). The literature shows that African Americans are twice as likely to be diagnosed and die from type 2 diabetes than Whites (Goode, 202; Office of Minority Health, 2023).

As of 2021, 12.7% (4.9 million) of African Americans have type 2 diabetes and are 2.6% times more likely than Whites to experience renal failure due to poor glycemic control, and other complications that include lower extremity amputations, cardiovascular disease that can lead to a stroke or heart attack and nerve damage (ADA, 2023; CDC 2023; Crabtree et al., 2015; Office of Minority Health, 2023; Williamson et al., 2018). African Americans with diabetes are also 46% more prevalent for visual impairment that can lead to blindness than Whites (ADA, 2023; CDC, 2023; Crabtree et al., 2015; Office of Minority Health, 2023; Williamson et al., 2018).

By 2050, an estimated 1 in 3 Americans will develop diabetes, and the number of African Americans with diabetes will increase by 107% (Gutierrez et al., 2014; Sumlin & Brown, 2017). Approximately 50% of African American women are likely to develop type 2 diabetes and experience diabetes-related complications, which are the leading causes of disability and death among African Americans (Sumlin & Brown, 2017; Willig et al., 2014).

Barriers to Care

In the United States, African Americans face ongoing disparities in healthcare access, quality care, and health outcomes (Hall et al., 2015; Lew et al., 2015; McQuade et al., 2021). According to Lew et al. (2015), diabetes prevention and self-management behaviors are adversely affected by poor access and quality of care. Hall et al. (2015) also reported that African Americans face more barriers than Whites in accessing preventive services such as health screenings and chronic disease management, which are imperative to diabetes self-management.

The barriers often experienced by African Americans with type 2 diabetes are related to “health disparities and social determinants of health such as environmental conditions in which they live, low socioeconomic status, and low health literacy” (Zisman-Ilani et al., 2023, p. 112). According to Zisman-Ilani et al. (2023), these social determinants of health can add

extraordinary and further burdens to the daily management of type 2 diabetes, causing interference with the quality of care compared to their White counterparts. These social determinants of health are also related to higher rates of disengagement, nonadherence to treatment, and worse health outcomes for African Americans (Zisman-Ilani et al., 2023).

Diabetes Stigma and Racial Discrimination

The literature shows that some African Americans believe that healthcare providers are purposely making them sick by withholding diabetes education due to racial discrimination (Shiyanbola et al., 2018). Shiyanbola et al. (2018) infer that there is a perception of race based on the color of one's skin and that diabetes for African Americans evolved out of poverty because of slavery.

Diabetes outcomes are affected by the stigma experienced when accessing help in African American communities. Health-related stigma is a psychological element that affects the lives of people with chronic medical conditions (Liu et al., 2017; Nyblade et al., 2029). Individuals with diabetes who experience self-stigma develop negative feelings, including self-blame, exclusion, or rejection (Liu et al., 2017). Studies have shown that people with diabetes stigma reported feelings of “fear, embarrassment, blame, guilt, anxiety, and low self-esteem” (Liu et al., 2017, p. 27). Self-stigma also has adverse effects on self-care behaviors related to diabetes, and the quality of care received from healthcare professionals is perceived as less than optimal (Puhl et al., 2020).

Diabetes and its Relationship to Food

Historically, food has played a significant role as a source of comfort for African Americans. Food in the Black community often brings people together, promoting community and connection while building memories and traditions. African American women are pivotal in

preserving food traditions because culturally, food represents “love, caring, financial wealth, and kinship” and “incorporates the intersection of history and the continued struggle for justice and equality” (Sumlin & Brown, 2017, p. 573). Also, for many African Americans, food has served as a means of coping with stressful situations, traumatic experiences, and the marginalization faced by Black people.

A descriptive ethnographic study by Sumlin and Brown (2017) focused on the cultural influences and symbolism of food practices among African American women with type 2 diabetes. The overarching theme was that African American women struggle with their food choices and diabetes management. Food practices for African Americans in the United States date back to slavery and symbolize the continued existence of African American communities (Sumlin & Brown, 2017). There is a perception that African Americans developed unhealthy eating habits during slavery due to being forced to make a meal out of the scraps and leftovers from the plantation owners, which resulted in their ancestors being later diagnosed with diabetes (Shiyanbola et al., 2018).

The study also noted multiple attempts to provide traditional diabetes education that incorporated recommended dietary changes in the Black community with little success. Studies have involved diet and Mexican American women, but none exist on traditional dietary changes for African American women (Sumlin & Brown, 2017). The authors noted that culturally tailored diabetes interventions for African American women with type 2 diabetes should “incorporate ethnic beliefs, values, customs, food patterns, language, and health care practices” (Sumlin & Brown, 2017, p. 573).

Only three studies have focused on the intersection of African American culture and dietary changes necessary for glycemic control, of which only one focused on diet (Sumlin &

Brown, 2017). According to Sumlin and Brown (2017), a gap in research persists concerning the food beliefs and practices of African American women with type 2 diabetes. Without this information, it is impossible to create culturally tailored diabetes education for African Americans to achieve sustainable health outcomes (Sumlin & Brown, 2017).

In summary, denying the craving for soul food, a tradition for African Americans, and opting for healthier choices is not always easy. Sumlin and Brown (2017) highlighted that African American women need to shift their thought processes to alter the cultural symbolism of food and make healthier choices to prolong life.

Historical Context

Medical Mistrust

When it comes to managing diabetes in the Black community, African Americans have little trust in the healthcare system due to the historical medical mistrust and racial injustices that are a result of systemic racism commonly experienced by African Americans (Shiyanbola et al., 2018). Many incidents of racial injustices have occurred dating back to the enslavement of African Americans. However, the Tuskegee Study of Untreated Syphilis, also known as the Tuskegee experiment, was a racist and unethical medical research project conducted by the U.S. Public Health Service and involving Black men in Tuskegee, Alabama, spanning 40 years from 1932 to 1972 (Alsan et al., 2020; Frazier, 2020).

The Tuskegee experiment has been often cited as the primary cause of medical mistrust among African Americans (Alsan et al., 2020; Frazier, 2020). This study began with 600 Black men, mostly poor and not formally educated, of whom two thirds ($n = 399$) had syphilis and the remaining third ($n = 201$) served as the control group (Alsan et al., 2020; Frazier, 2020). The men who had syphilis were not informed of their status and were told they were being treated for

bad blood. When the cure (penicillin) became the standardized treatment for syphilis, the men who were infected did not receive the treatment and the researchers continued to monitor them until the end of the project in 1972.

Many of the men who were not treated infected their wives and unborn children (Frazier, 2020). Once this tragedy became known, African American men who were not part of the study withdrew from seeking care from their healthcare providers; thus, mortality and medical mistrust increased. Because of the Tuskegee experiment, African Americans tend to avoid participating in clinical trials or becoming organ donors (Frazier, 2020).

Lack of Diversity in Healthcare

Dr. Uche Blackstock (2024), a physician and thought leader on bias and racism in health care, has noted that only 2% of physicians in the United States are Black women. Due to the lack of diversity in health care, African Americans continue to face systemic barriers in health care (Uche, 2014). African Americans need physicians who are a representation of themselves. In her book *Legacy: A Black Physician Reckons with Racism in Medicine*, Dr. Blackstock (2024) described racist practices and policies that ensure Black Americans have far worse health outcomes than any other group in America. She also described the flawed system that endangers the well-being of Black communities. Dr. Blackstock and her twin sister, a physician, followed in their mother's footsteps, becoming the first mother-daughter pair to graduate from Harvard Medical School.

Dr. Charles S. Thomas, the only Black endocrinologist at a large healthcare organization in Los Angeles, shared that he is the first Black physician some of his patients have ever encountered. He also shared his opinion below on the need for more representation of Black physicians, especially in endocrinology:

“There is still a lack of Black physicians in this country, and I see even fewer Black endocrinologists. I’m happy to be an example for others and hopefully an inspiration to young Black people who want to pursue a medical career” (Thomas, 2024, para.1).

Because of the growing number of diabetes cases among African Americans, there is still work needed in hiring practices to include diverse team members, especially African American physicians, which continues to be a systemic problem in healthcare.

Legislation on Diabetes

The most recent bill in the U.S. House of Representatives that addressed the incidence of type 2 diabetes among African Americans is the Eliminating Disparities in Diabetes Prevention, Access, and Care Act of 2015, HR 2615, introduced on June 4, 2015.

Eliminating Disparities in Diabetes Prevention, Access, and Care Act of 2015 is a bill that amends the Public Health Service Act to require the National Institutes of Health to (1) expand, intensify, and support activities regarding prediabetes and type 2 diabetes in minority populations; (2) award grants for a mentoring program for health care professionals to be more involved in weight counseling, obesity research, and nutrition; (3) provide for the participation of minority health professionals in diabetes-focused research programs; and (4) award grants for programs to establish a pipeline from high school to professional school that will increase minority representation in diabetes-focused health fields. (United States Congress, n.d., para. 1)

Other legislation on diabetes includes the Inflation Reduction Act signed by President Biden on August 16, 2022, in which a cap on the out-of-pocket cost of insulin for Medicare recipients was lowered to \$35 per month (U.S. Department of Health and Human Services, August 16, 2023). Also, the American Diabetes Association is advocating for continuous glucose

monitoring costs to be covered for all people with diabetes requiring insulin who have Medicare and Medi-Cal coverage at no cost (ADA, 2024).

Social Work Grand Challenges

Grand challenges for social work are a groundbreaking initiative to advocate for social evolution influenced by science. It is a call to action for researchers and social work practitioners to work together to undertake the nation's most challenging social problems (Grand Challenges for Social Work 2018). There are 13 grand challenges divided into three categories: individual and family well-being, stronger social fabric, and just society.

The lack of culturally tailored diabetes education is associated with two grand challenges for social work: closing the health gap and eliminating racism. Closing the health gap falls under individual and family wellness and emphasizes the “endured lasting effects of discrimination, poverty, and adverse environments that increase the rates of illness” (Williams, 2016, p. 67).

The societal goal of closing the health gap requires developing a socially oriented healthcare model that focuses on eliminating the core issues of health inequities that affect health outcomes, promoting innovative interventions, and primary care prevention to eradicate existing gaps in marginalized populations (Grand Challenges for Social Work, 2018). In 2016, researchers, policymakers, and practitioners set out to engage in various activities to address the health gap (Grand Challenges for Social Work, 2018). Some activities included advocating for justifiable health solutions, developing new health innovations in primary care, and promoting better access to healthcare (Grand Challenges for Social Work, 2018).

The goal to eliminate racism falls under efforts to ensure a just society, which involves addressing racial and ethnic disparities driven partly by implicit bias. Eliminating racism was added to the social work grand challenges in 2020 in the wake of the nationwide anti-racism

protests. This grand challenge emerged in response to the unjust treatment of African Americans around the country regarding police brutality. It also ties in with equality regarding human rights, access to health care, and quality care issues for African Americans.

This grand challenge represents “a call to action for social work practitioners and researchers to come together to eliminate racist policies, bias, and discrimination practices, focus on evidence and practice-based interventions and to provide support and accountability to move the social work profession forward” (Williams, 2016, p. 68; also see <https://grandchallengesforsocialwork.org>).

In conclusion, this chapter highlighted the growing number of diabetes cases among African Americans, supported by the alarming statistics, diabetes complications, barriers to care, stigma and racial discrimination, medical mistrust, and the lack of diversity in healthcare that contributes to the lack of culturally tailored diabetes education. This chapter also discussed the current legislative policies affecting individuals with diabetes and the social work grand challenges that are put in place to address the health gap and racist policies in health care. The next chapter will discuss integrating religion and theory to help understand this social problem.

CHAPTER 3: INTEGRATION

Integration is the third phase of the CESI Model that addresses the theoretical and theological concepts that help us to understand the social problem, its causes, and consequences. This chapter discusses the importance of spirituality and religion and its ties to the Black Church for African Americans. It speaks about spiritual and physical health's connection to the bible and the theoretical concepts that can help us understand the lack of diabetes education for African Americans.

Biblical Framework

Spirituality is a fundamental aspect of African American culture. It plays a significant role in belief systems related to health, health practices, and health outcomes (Clark, 2017). A religious worldview for Christians often involves having a personal relationship with God cultivated through faith and submitting one's life to Jesus (Lew et al., 2015). African Americans who attend church generally ascribe to "Christian beliefs providing a foundation for their worldview, informing their daily lives including the approach to health and well-being" (Lew et al., 2015). African Americans also rely on spirituality to cope with managing chronic diseases such as diabetes (Spruill et al., 2015).

In the Black church the importance of health is highly regarded and often viewed as a gift from God (Lew et al., 2015). It is the belief that spiritual and physical domains are two coexisting dimensions of health and that the activities of prayer and laying hands on church members can restore health (Lew et al., 2015). It is also a common belief in the Black church that God is the ultimate healer, which may be "realized through faith practices and or healthcare action based on divinely inspired medical knowledge" (Lew et al., 2015).

For many African Americans, religion and spirituality significantly influence their health beliefs (Goode, 2021). In the African American community, the Black Church is a trusted institution recognized as the epicenter of the community, “serving as an educational institution, social justice, and civil rights center, the emotional and psychological support for many African Americans in the community” (Rowland & Issac-Savage, 2014, p. 19). The Black Church is known for promoting health and fighting disparities. It often supports health care and health activities such as health screenings to address Black communities’ needs and disparities (Rowland & Issac-Savage 2014, p. 19).

The Bible is a blueprint that provides fundamental principles to guide personal choices in ways that promote health and prevent disease. The following scripture addresses health and can be applied to people with diabetes:

Or do you not know that your body is the temple of the Holy Spirit who is in you, whom you have from God, and you are not your own? For you were brought at a price; therefore glorify God in your body and your spirit, which are God’s. (New King James Version Bible, 2023, 1 Corinthians 6:19-20)

The church preaches faith, which can motivate health behavior changes related to managing diabetes, such as dietary modifications and increased physical activity. Faith can also aid in coping with stress to manage better emotional and physical challenges for those living with diabetes, and physical and spiritual health is associated with religious practices and beliefs associated with faith (Whitney et al., 2017).

For many years, the Black church has been regarded as an essential partner for health awareness activities in the community (Maxwell et al., 2019; Whitney et al., 2017). In 2019, many churches in Los Angeles reported having health ministries committed to improving their

congregants' overall health (Maxwell et al., 2019). Whitney et al. (2017) revealed that church-based health promotion programs are “effective, feasible, and acceptable in African American populations that experience limited access to health promotion programs” (p. 441).

Diabetes self-management teaching can be challenging and is not always available in primary care settings. Thus, literature has shown that community-based interventions can be successful and have a powerful “influence on beliefs and health care behaviors” (Goode, 2017). Faith-based organizations can be essential in promoting physical and mental health in communities (Ayton et al., 2017). Dr. Dorine Brand (2019) agreed that faith-based organizations can be crucial in promoting health programs, and many African American churches have succeeded in sponsoring health activities.

The literature has shown that medical mistrust, racial discrimination, and ongoing disparities in health care are systemic problems. Collaborating with the Black Church to provide culturally tailored diabetes education is one solution that could reduce the impact of diabetes cases and improve health outcomes in the Black community.

Theoretical Framework

The theoretical framework relevant to providing diabetes education in this population includes empowerment theory and the socioecological model of health.

Empowerment Theory

Empowerment theory focuses on empowering individuals to pursue change in ways that make them feel confident, inclusive, and supported. In health care, providers can assist patients with making informed decisions about their health (Tol et al., 2015). “Patient empowerment implies a patient-centered, collaborative approach that helps patients determine and develop the inherent capacity to be responsible for their own life” (Tol et al., 2015, p. 1).

From a social work lens, empowerment refers to “a social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life” (Mitchell & Hawkins, 2014, p. 518).

In the delivery of psychosocial care, social workers can use empowerment theory when working with African Americans by focusing on the value system of individuals and families that is unique to their experiences, relying on “personal values, beliefs, identities, and strengths to draw from for improving their situations or outcomes” (Mitchell & Hawkins, 2014, p. 518).

The use of empowerment theory with diabetic patients can involve shared decision-making, a process that emphasizes equity between patients and physicians regarding clinical care that is associated with better diabetes control and health outcomes (Whitney et al., 2017). It is a patient-centered collaborative model that helps patients develop an innate capacity to be responsible for their health.

The goal of providing culturally tailored education on diabetes for African Americans using empowerment theory is to provide them with the necessary tools to engage in a conversation about their diabetes care and self-management with confidence.

Socioecological Model

The socioecological model of health visualizes health broadly, emphasizing a range of factors that might affect health. This model outlines how health is affected by the relationship “between the individual, the group or community, and the physical, social, and political environments” (McCloskey, 2011, p. 20). This model is used to promote health and disease prevention. Black churches are known for promoting health activities such as health fairs that involve the community. Implementing culturally tailored diabetes education in the Black church

could result in lifestyle and behavior changes that promote and improve health outcomes for the community.

In conclusion, because culturally tailored diabetes education is not offered or readily available in the healthcare setting and to address the needs of African Americans, paired with the medical mistrust, the Black Church was chosen as the primary stakeholder and community partner because it is a trusted institution. The next chapter will detail the engagement phase with the Black Church and other community partners and members.

CHAPTER 4: ENGAGEMENT

Engagement is the fourth phase of the CESI Model that addresses community member's and stakeholders' understanding of the social problem, its causes, and solutions.

Community Engagement

Community engagement is a collaborative process that can address issues affecting a group's well-being based on where they live, their interests, or comparable situations (McCloskey et al., 2011). It is an influential approach to stimulate environmental and behavioral changes that can improve a community's and its members' health (McCloskey et al., 2011).

Community engagement often entails building partnerships and coalitions designed to help circulate “resources and influence systems, change relationships among partners, and serve as a change agent for transforming policies, programs, and practices” (McCloskey et al., 2011, p. 7). Community engagement is rooted in the “principles of community organization, fairness, justice, empowerment, participation, and self-determination” (McCloskey et al., 2011, p. 4).

Stakeholders, Community Partners, and Community Members

The main stakeholders and community partners included the Black Church and an all-Black expert healthcare panel. The community members included church members, health screeners, and other volunteers.

Charles Drew University

One of the initial stakeholders identified for this project was the Charles Drew University of Medicine and Science's Kedren Mobile Medicine Program. They agreed to staff their mobile van and provide health screenings for the health fair six months before innovation day. However, they withdrew their commitment three months before innovation day due to financial reasons. This incident led to the search for new volunteers to perform the health screenings.

Great Shepherd Missionary Baptist Church

The community organization partnered with to conduct this innovative project, Empowering My Community: Health Fair and Symposium on Culturally Tailored Diabetes Education for African Americans, was with Great Shepherd Missionary Baptist Church under the leadership of Rev Darryl Moore. The church is in an underserved area of Los Angeles. The membership is predominantly Black, with a congregation of less than 100 people. The church has been a fixture in the community for 60 years. Rev. Moore has been a Pastor for over 20 years, including the last 8 years with Great Shepherd Missionary Baptist Church.

Rev. Moore expressed concern about the growing number of diabetes cases affecting African Americans and eagerly offered his church as the venue to host a health fair and symposium on culturally tailored diabetes education. The conversation about this innovation began more than a year ago.

Expert Healthcare Panel

A group of healthcare providers with relevant experience in treating diabetes patients was assembled as an expert panel to provide culturally tailored diabetes education at the symposium. All panelists were African American and employed by a local health maintenance organization. The keynote speaker was a family medicine physician and the equity, diversity, and inclusion leader in the organization's Riverside service area. The panelists consisted of a registered dietician and a director of food and nutrition services, a senior consultant specializing in diabetes and hypertension from Northern California, and a licensed clinical social worker from Los Angeles who has a private practice and works as a contractor for a health maintenance organization.

Leadership Strategies

To be an effective leader requires certain leadership qualities. The leadership strategies employed for this project were collaboration, compassion, competence, empathy, empowerment, faith, honesty, humility, integrity, passion, respect, service, transparency, and trust. The leadership style used for this innovation was transformational leadership.

Transformational leadership is about focusing on what is needed to bring about change. It involves empowerment, inspiration, and innovation. It enables individuals to feel empowered, confident in finding their voice, and able to engage with healthcare providers regarding diabetes management (Allen et al., 2013; Hauck et al., 2013).

It was essential first to establish trust with Rev. Moore and his wife, which fostered motivation through shared decision-making, leading to a shared vision of innovation that aligned with the mission and vision of the church (Geer et al., 2008). This leadership style is essential in creating a culture centered on service—in this case, enabling individuals to benefit from the innovation designed to improve their health outcomes (Allen et al., 2013).

Rev. Moore and his wife were adamant about meeting the members' needs. The ultimate goal of the innovation was to empower church members to take control of their health by learning how to engage confidently with their healthcare providers about their diabetes management.

Engagement Strategies with Stakeholders

The literature has shown that community engagement strategies improve health promotion. Based on the community engagement model, the following strategies were employed for this innovation: collaboration, shared decision-making, engagement, trust, support, transparency, community participation, and outreach.

During the strategic planning phase and throughout this project, trust was built through ongoing collaboration with the pastor and first lady. It was essential to establish clear goals to ensure decisions about the innovation were shared, well-informed, and collectively supported. Weekly meetings were held to discuss the timeline of events leading up to the day of innovation.

A planning committee of chosen members, including the pastor, the pastor's wife, the head of hospitality, and the media person, was established to generate ideas and discuss the responsibilities and tasks required for volunteers on innovation day. It was also critical to exercise transparency and involve the congregation in soliciting their support for this innovation. Support was gained by speaking to the congregation three months before the event, explaining the innovation's purpose and importance.

The search for a keynote speaker began 5 months before the innovation. The search for other speakers to serve as expert panelists started 3 months before the innovation day. Collaboration was the primary strategy employed in communicating with the keynote speaker and panelists regarding the purpose and goal of the symposium and the expectations regarding their roles.

The initial contact with the licensed clinical social worker, who was a member of the church, occurred in person, as did all subsequent communication, after church on Sundays. Follow-up communication with the other panelists was by email and online messages. One week before the event, an online video meeting was held with the keynote speaker, two panelists, and the regional senior director of communications for the health maintenance organization as a meet-and-greet to review expectations for each presentation and the flow of the symposium. Also, three questions about their specialty and the most frequent questions they are asked were

requested by email to be used at the symposium as an icebreaker to start the question-and-answer session, if needed.

The engagement strategies used with the planning committee were collaboration, shared decision-making, and transparency (i.e., accountability, honesty, and openness). Two months before the day of innovation, weekly meetings with the planning committee were held to review communication and marketing strategies, a diagram of the event setup, and other logistical details regarding the health fair and symposium.

Community-Based Participatory Research Methodologies

Community-based participatory research (CBPR) is a valued research approach. It supports those affected by a problem through their engagement and participation in the research process while “appreciating particular strengths and resources that each stakeholder contributes to the process” (SAMHSA Evidence-Based Resource Guide Series).

Representatives of Great Shepherd Missionary Baptist Church recognized the number of diabetes cases in the church and surrounding community. They shared their desire to make a difference by providing a venue for EMC to provide culturally tailored diabetes education to the church and surrounding community to promote better health outcomes for African Americans. The writer suggested conducting a needs assessment as part of the engagement process to determine what the congregation members wanted to know about diabetes to guide the education for the symposium. The needs assessment was conducted as an exploratory study.

The exploratory study consisted of eight individuals—six women and two men—using a questionnaire composed of 13 questions to assess their or a loved one’s diabetes status, understanding of diabetes, diabetes complications, experience with diabetes stigma, implicit bias, or racial discrimination by a healthcare provider; level of education received before or after

diagnosis; and thoughts on attending a symposium on culturally tailored diabetes education offered in the Black Church.

The results indicated that four of the participants answered that they had type 2 diabetes, and four answered that their loved ones had type 2 diabetes, including four who were dependent on insulin. The number of years with type 2 diabetes ranged from 2 years to more than 30 years. They all reported being told by their healthcare provider that diabetes can cause visual impairment, leading to blindness. Four indicated they had a good understanding of diabetes. All eight received diabetes education after being diagnosed through referral to a diabetes class; all eight reported that no culturally tailored diet education was offered, and only five found the education helpful. Seven attended a Black Church, and all eight reported they would feel comfortable attending a diabetes educational forum provided by the Black Church because it is a trusted institution. For results of the exploratory study, please see figures 2-16 in the appendix.

Overall, the results of the exploratory study highlighted that these participants experienced a delay in the healthcare setting in being offered diabetes education after a diagnosis, with no proactive preventive care provided. Also, it appeared that the education they received was substandard, especially regarding diabetes complications and culturally tailored education on diet, given poor glycemic control is linked to diet. The results were overwhelmingly positive regarding their interest in receiving culturally tailored diabetes education offered by the Black Church because of its trust and relatability.

CHAPTER 5: ASSESSMENT

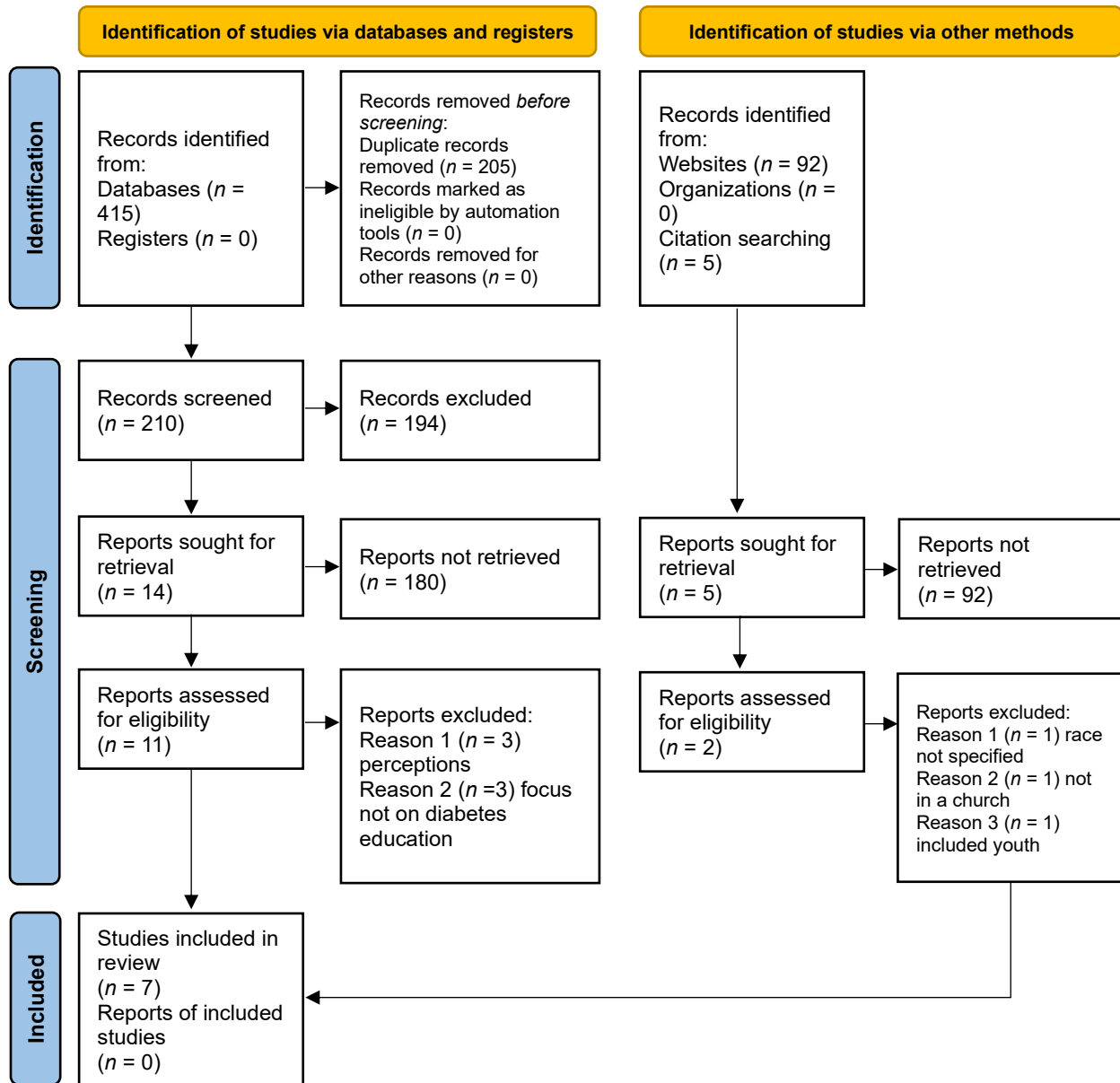
Assessment is phase five of the CESI Model that looks at what has already been done to address the social problem and the needs of a specific community impacted by the problem.

In assessing the research literature relevant to the social problem—the lack of culturally tailored diabetes education, it can be linked to the prevalence of diabetes among African Americans compared to Whites—complications, morbidity and mortality rates, health equity issues, implicit bias, racial discrimination, stigma, and medical mistrust contribute to the lack of culturally tailored diabetes education for African Americans.

This writer conducted a scoping review a year ago to examine diabetes education initiatives in the Black Church that could potentially reduce the impact of diabetes cases and improve health outcomes for African Americans. A systematic approach was used to explore peer-reviewed studies, grey literature, and citations to assess research on diabetes education in the Black Church. In a 10-year block from July 2013 to July 2023, only seven peer-reviewed articles met the inclusion and exclusion criteria for the study. See the PRISMA flow chart for the systematic review in Figure 1.

Figure 1

PRISMA Flow Diagram



Note. For more information, visit <http://www.prisma-statement.org> or see Page et al. (2021).

Summary of Scoping Review

The scoping review examined the research question, “What diabetes education exists in the Black Church to improve health outcomes for African Americans experiencing diabetes?” Of

415 studies identified from various databases, 92 from grey literature, and five from citation searching, only seven met the inclusion criteria for the study. The inclusion criteria included studies that offered diabetes education in the Black Church for adults aged 18 or older experiencing diabetes in the United States.

The analysis of the studies identified four themes: (a) culture: all participants were African American and members of a Black church with similar beliefs and values; (b) geographic location: all studies were conducted in major cities in predominantly Black neighborhoods in the Midwest, Southwest, and East (no identified studies occurred on the West Coast); (c) health: all participants had diabetes, prediabetes, or risk of diabetes and participated in a diabetes education program; and (d) relational factors: all participants had a relationship with the Black Church and a pastor and had a belief in God.

All studies used measurement tools such as pretests, posttests, surveys, and diabetes knowledge assessments to collect nutrition, physical activity, and glucose monitoring data. Only one study used a theoretical approach, and the remaining six used a community-based chronic care model.

The literature review found many studies on health awareness activities provided by the Black Church related to cancer, HIV, and smoking cessation, to name a few, but they were conducted more than 10 years ago. The literature review identified limited studies on diabetes education offered in the Black Church. Some studies involved education in the community outside of a faith-based organization and were not peer-reviewed. The growing number of diabetes cases among African Americans and the Black Church representing a trusted institution and a vehicle for promoting health and wellness in the Black community led to this innovation and partnership with the Black Church.

The next chapter highlights the development and execution of the innovation guided by the CESI Model and informed by the stakeholders and community members.

CHAPTER 6: INNOVATION

Innovation is the sixth phase of the CESI Model that highlights what new products, services, programs, and processes are developed to address the social problem and meet the community's needs.

Social Innovation

EMC was designed to serve as a platform to bring awareness and provide culturally tailored education on diabetes to underserved communities. The target population was African Americans. This innovation involved a community health fair that offered free health screenings for blood sugar and blood pressure; participation from various vendors such as the American Diabetes Association, which provided educational materials on diabetes, and a demonstration by a dietician using food props to teach attendees how to read labels for nutritional value, choose healthy foods, manage portion sizes, and plate food; and a symposium on culturally tailored diabetes education.

The symposium featured an all-Black panel of healthcare experts consisting of a keynote speaker, family medicine physician, registered dietician, health consultant, and licensed clinic social worker who engaged in a question-and-answer session on diabetes in the Black community. The writer served as the moderator for the symposium to ensure that the panelists addressed questions ranging from self-management, diabetes stigma, diet, exercise, medications, coping skills (mental health), and the complications of diabetes, such as blindness, cardiovascular issues, kidney failure, and limb amputations.

Development of Innovation

The idea of a community engagement project with the church was inspired by a class on community engagement and social innovation in 2021, part of the curriculum for the Doctor of

Social Work program at California Baptist University. This class explored the practice of community engagement as a vehicle for creating new and effective strategies for addressing complex social problems. The professor who taught the class was a pastor who supported partnering with a Black Church as a primary stakeholder. This was very encouraging and inspiring.

The literature shows that the Black Church is a trusted institution by those who attend, and they are most likely to take their health issues and problems to their pastor before going to a doctor due to medical mistrust. This phenomenon was observed on many occasions and warranted further investigation and research.

This innovation resulted from professional and firsthand experiences working with diabetes patients. Discussions with the main stakeholder, Great Shepherd Missionary Baptist Church, began more than a year ago, focusing on the growing number of diabetes cases among African Americans. The concept of creating something with the potential to address the increasing number of diabetes cases among African Americans by partnering with the Black Church began to manifest. The pastor gave his blessing to talk with parishioners about diabetes and their thoughts on an event (i.e., innovation) to address diabetes in the church and surrounding community.

A 13-question questionnaire was created for an exploratory study, along with interviews with church members about diabetes, before the innovation. The purpose of the exploratory study was to assess their knowledge of diabetes to determine what type of education would best serve the population. The results revealed that culturally tailored diabetes education was needed for African Americans, particularly regarding general self-management and diet. The results of the exploratory study were discussed in Chapter 4: Engagement.

CESI Model

This innovation was guided by the Community Engagement and Social Innovation Model using its eight-phase plan (Hays et al, 2023). Phases 2–5 involve research, and Phases 6–8 involve innovation, evaluation, and dissemination, respectively. Phases 1–5 were used to develop the innovation.

Phase 1, observation, highlighted personal and professional experiences that led to the awareness of the social problem and set the tone for social innovation. Phase 2 identified the problem and the target population that was impacted. Phase 3, integration, helps to understand the Christian worldview, how the church defined the problem, and theological concepts related to the cause and effect of the social problem. Phase 4, engagement, allowed for an understanding of the stakeholders' (pastors) and community members' perspectives and knowledge of the social problem, causes, and viable solutions. Phase 5, assessment, involved considering what has already been done to address the problem and the specific needs of the community impacted by the problem.

Phase 6, innovation, involved hosting a health fair and symposium on culturally tailored diabetes education for African Americans to meet the needs of the community and to promote better health outcomes. Phase 7, evaluation, involved whether the outcome of the innovation met the need of the community based on the results of the pre and posttests. Phase 8, Dissemination, involved how will the innovation be shared with the community and stakeholders.

Piloting Innovation

The innovation, EMC, was piloted on Sunday, April 28, 2024, from 11 a.m. to 3 p.m. at Great Shepherd Missionary Baptist Church in Los Angeles, California. The event was held on a Sunday following church service to ensure member participation. Set-up began at 8 a.m.

(breakfast was provided for all volunteers) with balloons and the event banner hung on the church parking lot fence to attract other people to the event.

All necessary forms and items for the registration table (consent forms, health screening forms, patient analysis forms, volunteer forms, demographic surveys, community resources for medical follow-up, hand sanitizer, receptacle for raffle tickets, pens, paper clips, and clipboards) and swag bags with give-away items that included an EMC wrist band, bible magnet, journal with bible verse, ink pen and diabetes awareness lapel pin kept underneath the table and given to the participants registered for health screenings. Participants completed the demographic survey upon registration for the health fair.

The screening table for blood sugar screening was arranged with supplies (two glucometers to test blood sugar, lancets, testing strips, alcohol pads, sharps container, bandages, first aid kit, hand sanitizer, gloves, pens, and clipboards) with additional supplies stored underneath the table. Once blood sugar was tested by registered nurses, the results were written on a blood sugar screening form with target ranges and when to follow up with a physician. Participants kept this form.

The screening table for blood pressure was arranged with supplies (manual blood pressure monitors, an electrical monitor, alcohol wipes to clean stethoscopes after each use, gloves, hand sanitizer, ink pens, and clipboards), and each nurse had a stethoscope. Once the blood pressure was taken by a registered nurse or licensed vocational nurse, the results were written on a screening form that provided information on target ranges and when to follow up with a physician. Participants kept this form.

If participants had a blood sugar or blood pressure level that was out of range, they were directed to follow the guidelines on the form by the on-site healthcare providers. If the

participants wanted to speak to one of the three on-site physicians, the physicians could provide guidance on the next steps. The pastor's wife, deacons, and other volunteers from the church arrived at 8:30 a.m. to assist with set-up. The pastor prayed for a successful event and thanked all the volunteers who supported the event.

The vendors were told to arrive 30–45 minutes before the start of the health fair to set up their tables. The health fair began at 11 a.m. and ended at 3 p.m. The volunteers stayed at their tables throughout the health fair. The speakers for the symposium were told to arrive by 11:30 a.m. but were encouraged to arrive at 11 a.m. to experience the health fair. All speakers arrived early, and the dietician set up her table to provide food demonstrations.

The health fair coordinator (this writer) began to direct the participants at the health fair into the church sanctuary at 12:05 p.m. to start the symposium by 12:15 p.m. The volunteers handed a pretest survey to all participants who entered the sanctuary to complete before the start of the symposium. Once everyone was inside, the health fair coordinator introduced herself, provided housekeeping instructions, and asked anyone who did not receive a pretest survey to raise their hand and one was provided. An introduction to the program and expectations was provided. At 12:20 p.m., the keynote speaker was introduced, and after their 20-minute presentation on diabetes, each panelist took 3–5 minutes to introduce themselves and discuss their role in working with diabetes patients.

After introductions, the question-and-answer session began. There was a 15-minute intermission, and once the symposium resumed, several raffle tickets were drawn for the opportunity drawing in which diabetic cookbooks and diabetic food logs were given away. This kept the audience engaged, and the last ticket was drawn once the question-and-answer session

was over. The volunteers passed out the posttest survey approximately 10–15 minutes before the end of the symposium and collected them at the end.

The audience engaged with the panelists throughout the symposium and were free to ask questions. They were directed in the beginning to ask questions they did not have an opportunity to ask their primary care physician. The education provided was culturally tailored to African Americans and tools were provided to address stigma, implicit bias, and racial discrimination encountered by non-Black physicians by an all-panel. The symposium ended on time, and everyone was directed back to the parking lot to take part in a healthy meal prepared at a live hibachi station. Each participant received a meal ticket at check-in, and everyone partook in the food and sat at tables, assembled in fellowship as they spoke about the impact of the symposium. Most had a chance to talk to the panelists, doctors, and other healthcare providers who volunteered that day. Based on the outcome of this innovation, it successfully met the goals.

Based on the outcome of this pilot test, EMC has the potential to reach African Americans in other underserved communities who are interested in receiving culturally tailored diabetes education. Having an all-Black expert panel of healthcare providers proved successful because the participants asked questions they typically would not ask of White providers for fear of them not understanding their culture. The participants' engagement based on their questions indicated they were concerned about diabetes and ways to reduce or avoid diabetes complications.

The small venue was an intimate setting that allowed for comfort and relatability. The participants reported to the writer that they felt a sense of comfort, did not feel ignored, and could ask questions without judgment. The participants were candid about their diabetes status and inquired about the lack of diversity in healthcare. They also emphasized medical mistrust as

a reason for not seeking medical attention regularly. Most participants said they belonged to a Black church and commented that more forums like this would be helpful in their daily management of diabetes.

Continuous Quality Improvement

Due to the prevalence of diabetes and the high cost associated with accessing care, there is a critical need to develop healthcare programs that enhance access, improve outcomes, and decrease the cost and human burden of diabetes (Rodriguez et al., 2022). Diabetes care and education specialists are in a great position to support healthcare organizations with delivery models that enrich diabetes care through evidence-based benchmarks and quality improvement plans (Rodriguez et al., 2022). Only two evidence-based programs provide national certification in diabetes care, outlining the most current competencies for guiding the practice of diabetes care (Rodriguez et al., 2022).

Studies have focused on diabetes self-management techniques such as diet, exercise, self-monitoring, medications, and how patients use the healthcare system (Ricci-Cabello et al., 2013). African Americans have been targeted for diabetes interventions, but few studies have explored effective continuous quality improvement strategies for this population (Ricci-Cabello et al., 2013). EMC focuses on the same critical factors, emphasizing the lack of culturally tailored diabetes education as a contributing factor affecting self-management. EMC was designed to serve as a platform to bring awareness and provide culturally tailored education on diabetes to African Americans in the Black Church.

Employing the same concept that diabetes care and education specialists must support healthcare organizations with delivery models enriching diabetes care, EMC aims to educate by raising awareness and increasing knowledge on self-management via an all-Black panel of

healthcare providers, preferably a multidisciplinary team to improve diabetes self-management and improve health outcomes for African Americans. In doing so, this forum can potentially reduce the financial and human burden of diabetes.

Ethical Considerations

For this innovation, ethics were considered from the beginning. Due to the tight space for the health screenings, the participants could overhear conversations with the other participants and screeners. This was not an issue unless there was a situation that warranted consultation as there was no other place available to have these conversations.

However, there was one incident that occurred in which a participant completed a blood pressure screening that yielded a dangerously high reading several times. This prompted three physicians to earnestly attempt for nearly 35 minutes to convince the participant to seek immediate medical attention, but he declined. The physicians decided to pull back because they noticed that the patient was becoming overwhelmed by all the attention.

This situation highlighted social work code of ethics guidelines involving self-determination (respect), privacy, and confidentiality. One involved a potential violation of a foundational ethical principle, in which the participant's respect for autonomy may have been violated. Also, regarding self-determination, individuals have the right to refuse services or advice. Not having a private area for participants when discussing results that are not favorable involved a potential health privacy right violation. However, the participants granted his permission to discuss his blood pressure reading and the other participants were asked to step away. There was no breach of information and no one discussed his results in front of anyone else.

CHAPTER 7: EVALUATION

Evaluation is the seventh phase of the CESI Model that speaks to what evidence is there that the innovation accomplished the desired outcomes and met community needs.

The focus of the symposium was to provide culturally tailored diabetes education. The goal was to improve the health outcomes of African Americans with diabetes by offering tools for better self-management and to address stigma, implicit bias, and racial disparities encountered in the healthcare system. The measurable objectives that the symposium sought to accomplish include:

- Raise awareness and understanding: increase understanding of predisposition (family history) and the importance of early intervention in prediabetes to prevent or delay disease onset
- Increase diabetes self-management knowledge: emphasize the importance of culturally tailored diabetes education to promote better health outcomes
- Decrease stigma around diabetes: provide tools to address stigma, implicit bias, and racial disparities

Evaluation Method

An outcome evaluation was used to assess this innovation. Paper surveys were used to collect data using a 7-item pretest and posttest approach. Demographic questions were completed upon registration at the health fair, and each participant's age, gender, ethnicity, marital status, and relationship with the Black Church were captured to determine the characteristics of those attending the health fair. For results, see Figures 17–21 in the Appendix.

The pretest and posttest surveys contained identical questions to measure participants' diabetes status, understanding of diabetes, thoughts on diabetes being a severe health condition,

if diet is essential in managing diabetes, thoughts on culturally tailored education promoting better health outcomes for African Americans, whether having a voice in a diabetes treatment plan is a motivating factor for lifestyle changes, and recognition that self-control of diabetes health and positive changes are possible. For pretest and posttest results, see Figures 22–28 in the Appendix.

Relevant Financial Plans and Project Accountability

The keynote speaker and panelists in this pilot test provided their expertise without charge. However, personalized gifts and other items were provided in appreciation for their time. Also, they received lunch and snacks throughout the day. The caterer was provided with a monetary donation and an in-kind donation letter for the food served to the participants. During the symposium’s housekeeping instructions, the participants were encouraged to donate (if possible) when they received their food to offset the caterer’s time allocated to this project.

There was no cost to secure the vendors, and they were not charged a registration fee for their tables. They received a swag bag and lunch in appreciation for attending the health fair and symposium. The volunteers (health screeners, deacons, and other church members) graciously offered their time to assist with setup. They received breakfast in the morning in recognition of their help. All volunteers also received an EMC T-shirt and swag bag.

A clean-up crew of two were hired to assist the health fair coordinator (writer) for the day. Their duties included loading and unloading the truck with all health fair and symposium items and supplies. Other expenses include the cost of 26 EMC T-shirts for the volunteers, health screeners, keynote speaker, panelists, pastor, and first lady. This was a good investment because it provided easy identification of the volunteers and served as advertising for Social Work

Practitioners Place. Other branding materials included the banner for the event, personalized pens, and diabetes awareness bands with the EMC logo.

Other expenses included a videographer; personalized tumblers for volunteer screeners, panelists, and planning committee members; opportunity drawing giveaways; swag bag items that included marketing items; diabetes lapel pins; Bible magnets; and inspirational journals; and children's activities, snacks, water and items necessary to conduct health screenings.

For future EMC events, the churches will absorb the cost or seek out a sponsor to cover expenses.

CHAPTER 8: DISSEMINATION

Dissemination is the eighth and final phase of the CESI Model, which discusses how the innovation was shared with stakeholders and community members.

Empowering My Community Health Fair and Symposium on Culturally Tailored Diabetes piloted on April 28, 2024, at a church in Los Angeles, California. The health fair offered diabetes and blood pressure screenings. There were also several vendors, such as the American Diabetes Association and National Kidney Foundation, that were present to provide valuable health information.

The symposium focused on culturally tailored diabetes education, offering tools for better self-management and addressing diabetes stigma, implicit bias, and racial disparities encountered in the healthcare system. The aim of the symposium was to raise awareness and increase knowledge on diabetes self-management to improve health outcomes for African Americans.

The educational content for the symposium was prompted by the implementation of the CESI Model and informed by the community members and stakeholders through an exploratory study conducted on the understanding of diabetes referenced in the engagement section. The findings of the exploratory study indicated the need for a symposium on culturally tailored diabetes education for African Americans.

Recommendations for Practice

Future marketing plans for Empowering My Community (EMC) include building partnerships with local Black churches in underserved areas of California's Inland Empire (Riverside and San Bernardino counties). Meeting agendas will discuss the growing number of diabetes cases affecting African Americans. EMC will share its vision and offer services to assist Black churches in planning or hosting a health fair or symposium on culturally tailored diabetes

education. Furthermore, event day activities will focus on raising awareness and increasing knowledge of diabetes self-management to improve health outcomes for African Americans. Additional marketing communication tools include adding a blog to the Social Work Practitioners' Place website, email, flyers, various social media platforms, public service announcements via the radio, and word of mouth.

EMC's expanded marketing plan includes offering its clients (Black churches) a do-it-yourself option, charging a fee for the planning manual to guide them step-by-step through organizing and implementing their EMC event. Other fee services include consulting to assist churches with the planning process and onsite coordinator services on the event day.

Lastly, EMC will secure its brand by registering for a trademark, obtaining service branding for the logo and name, and event branding for the experience.

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APPENDIX

Figure 2

Diabetes Status

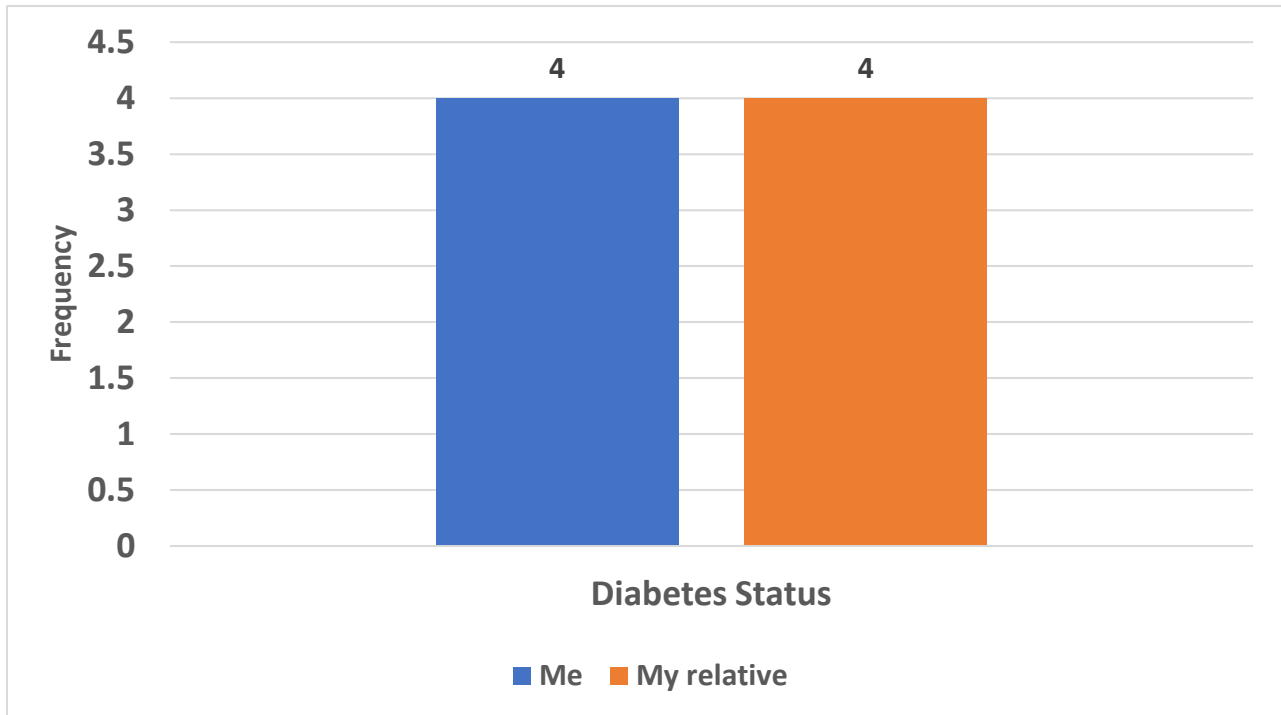


Figure 3

Diabetes Type

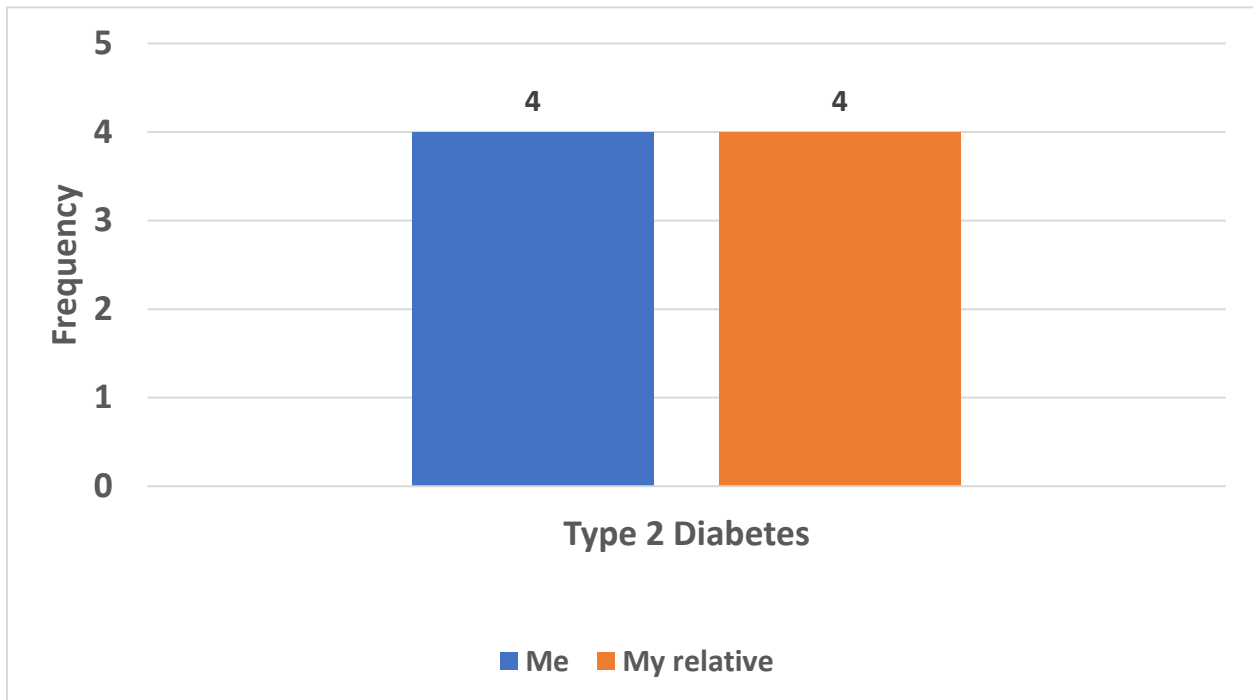


Figure 4

Number of Years with Diabetes

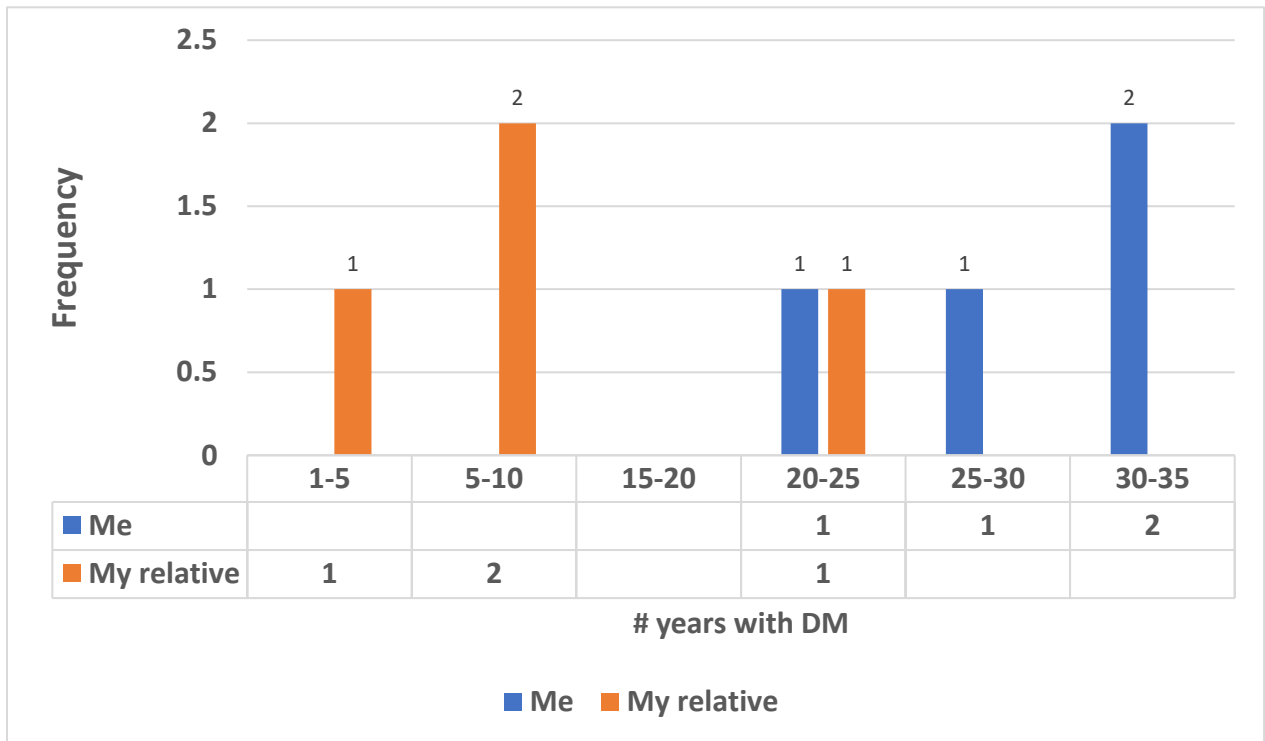


Figure 5

Insulin Dependence

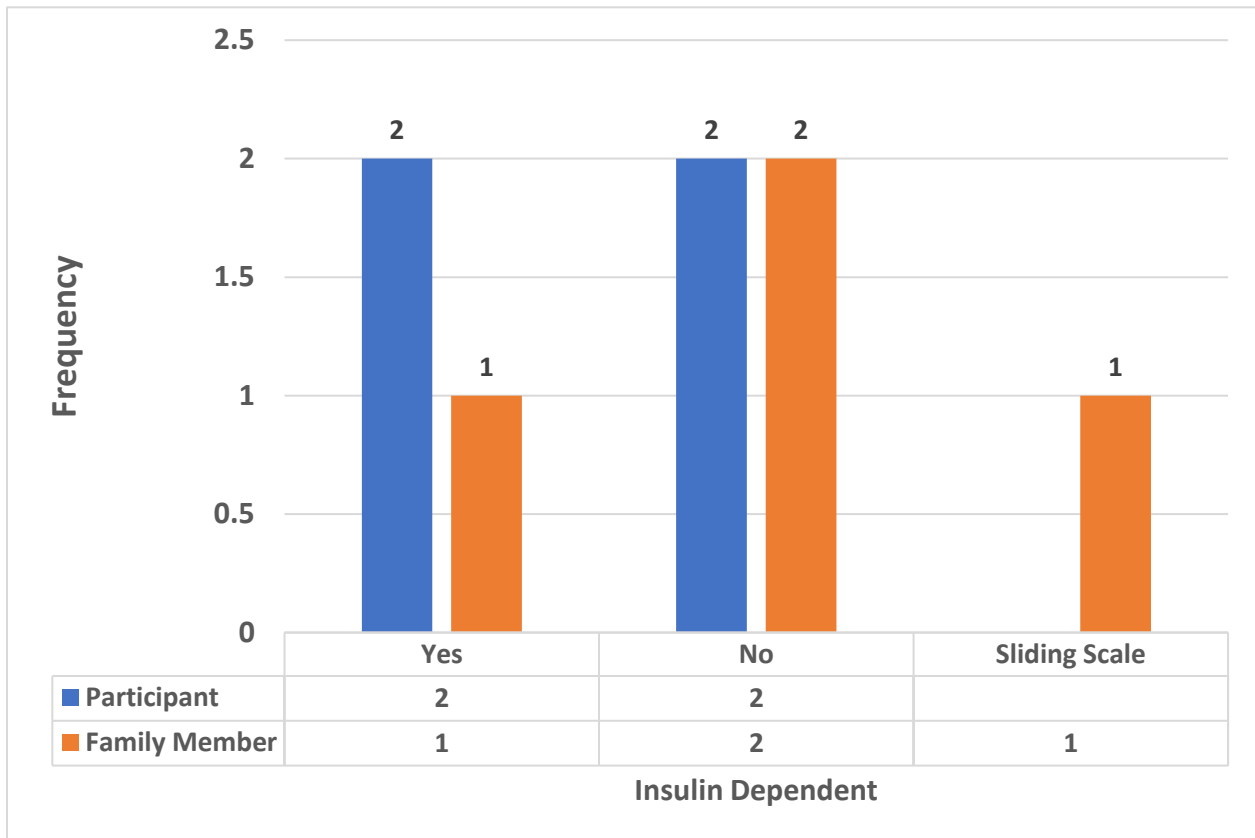
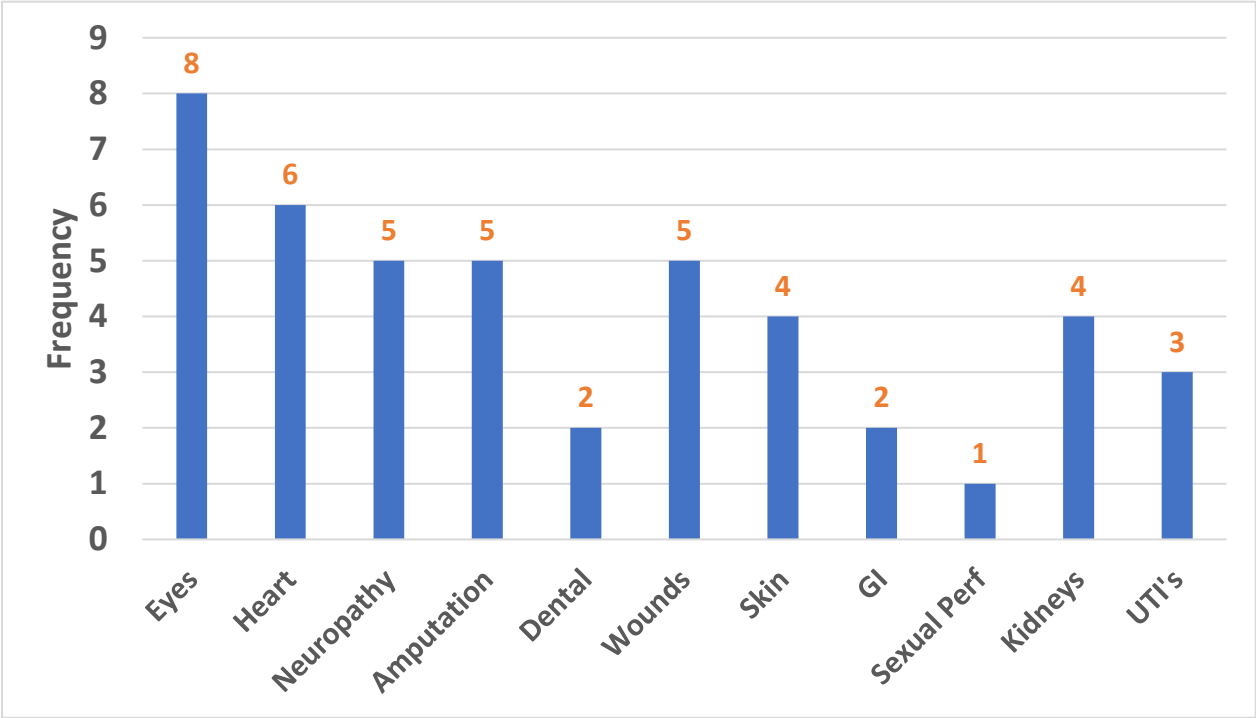


Figure 6

Doctor-Informed Diabetes Complications



Note. GI = gastrointestinal; UTI = urinary tract infections

Figure 7

Understanding of Diabetes

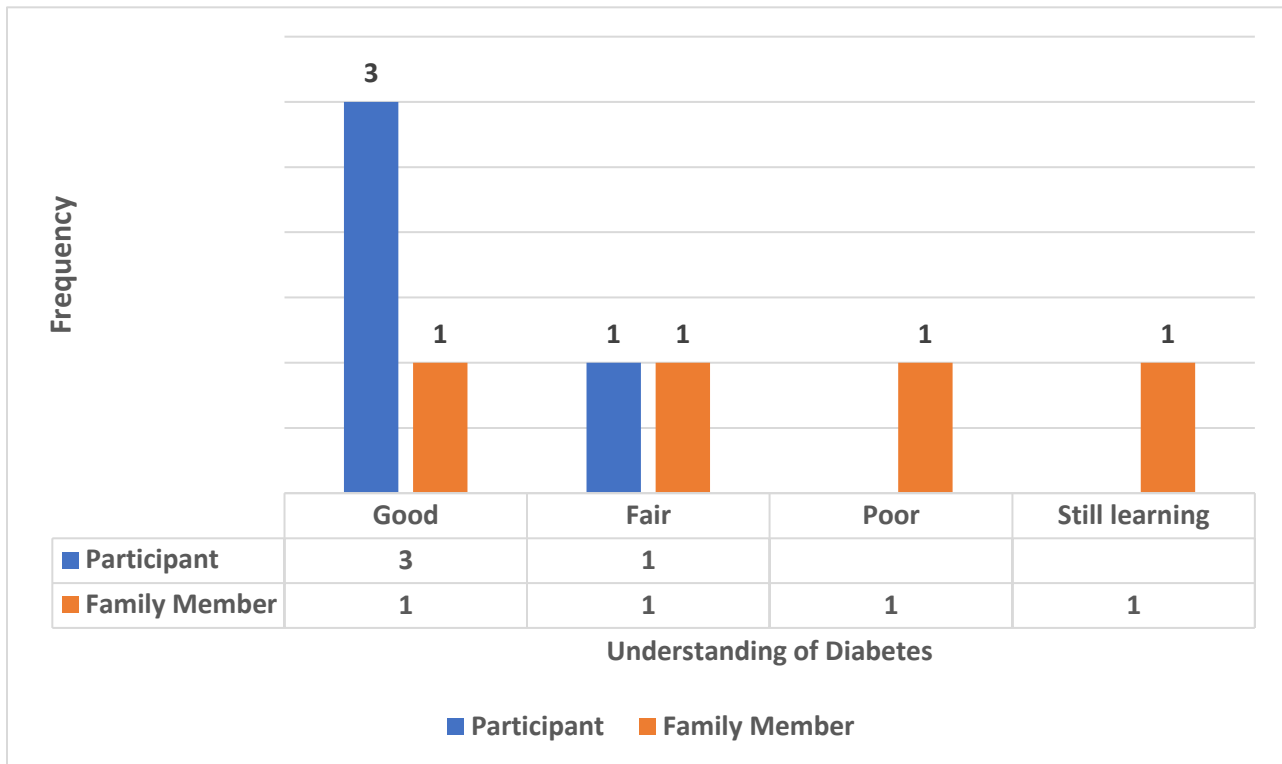


Figure 8

Diabetes Education Provided by Healthcare Provider

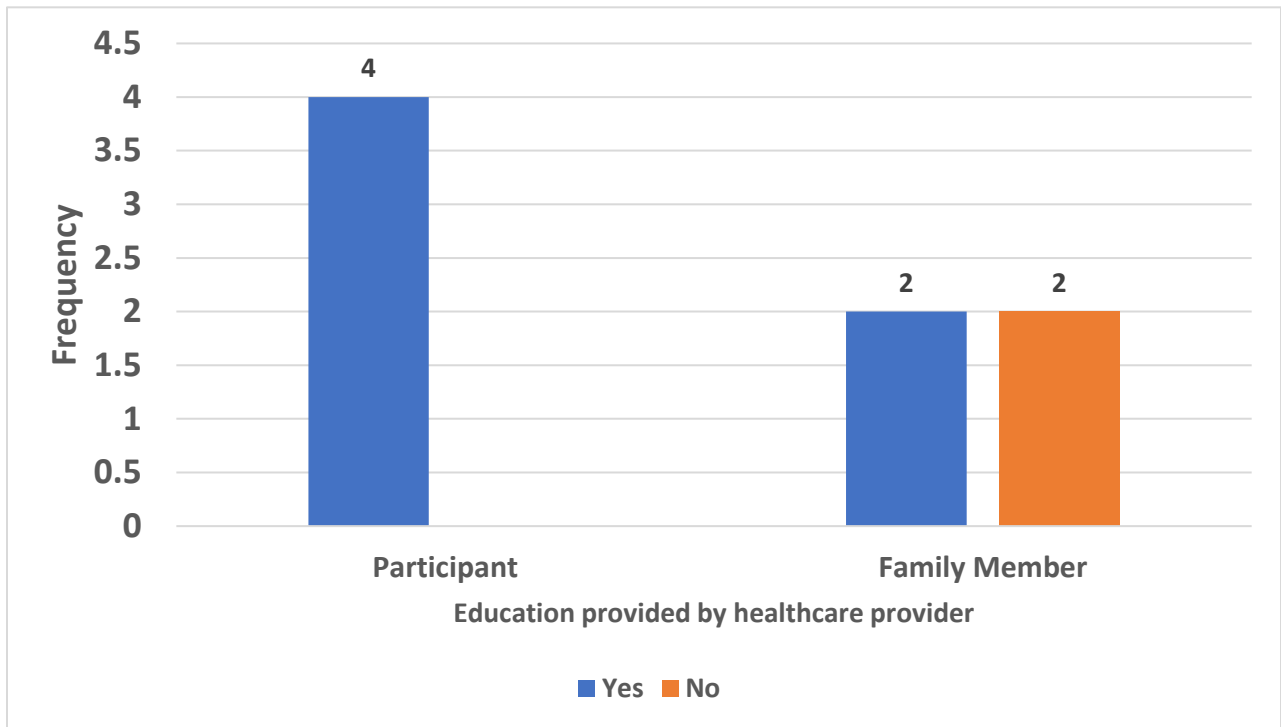


Figure 9

Diabetes Education Received Before or After Diagnosis

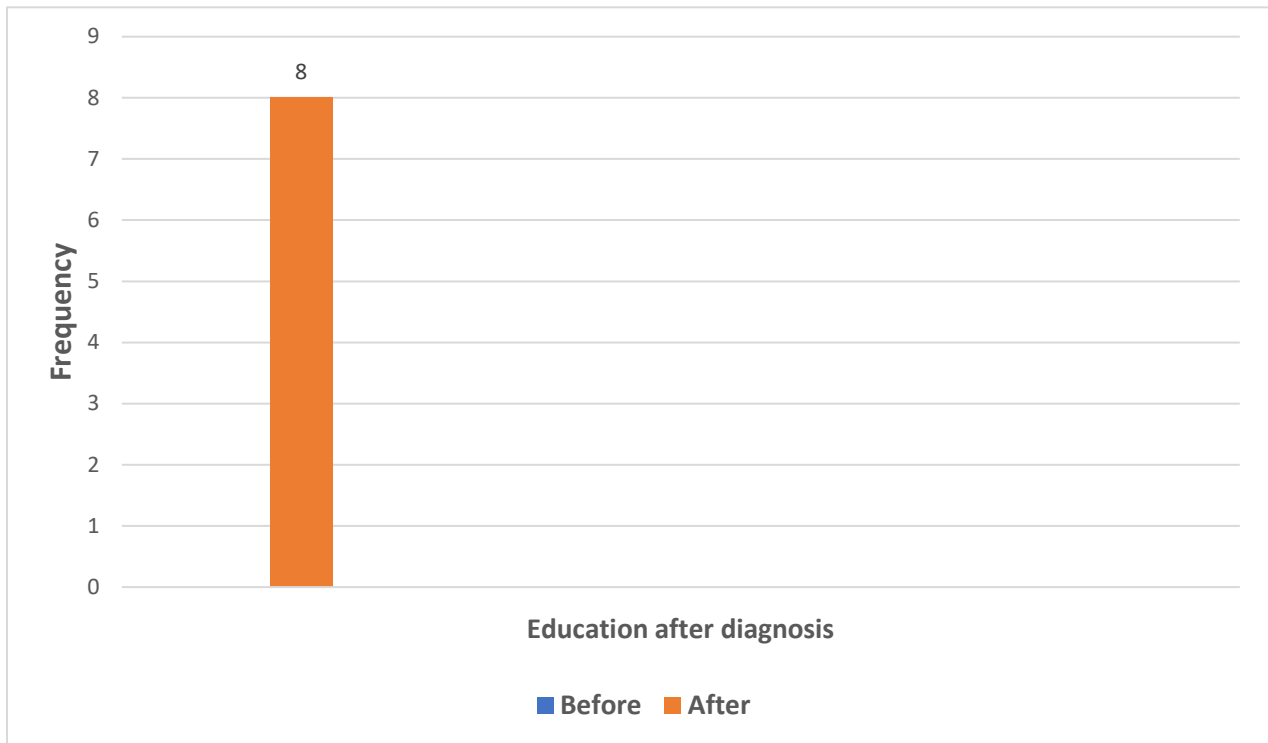


Figure 10

Type of Diabetes Education Received

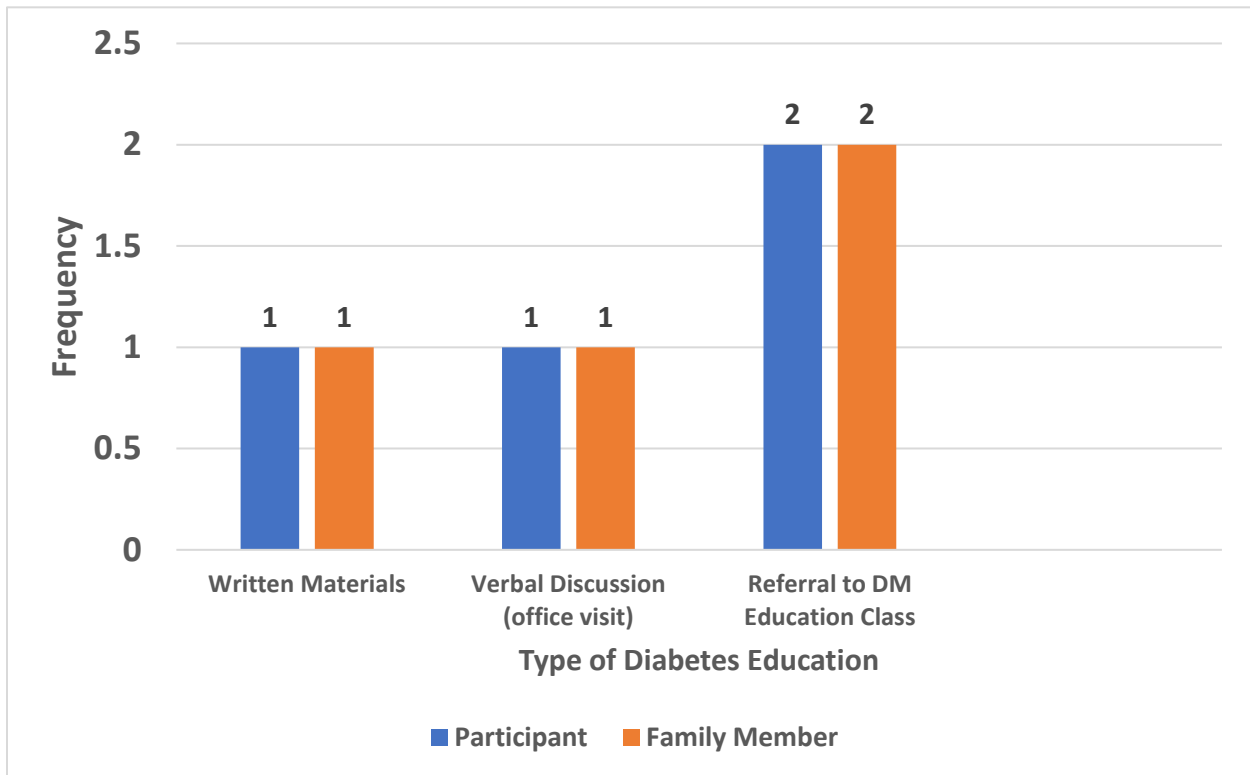


Figure 11

Was the Education Helpful

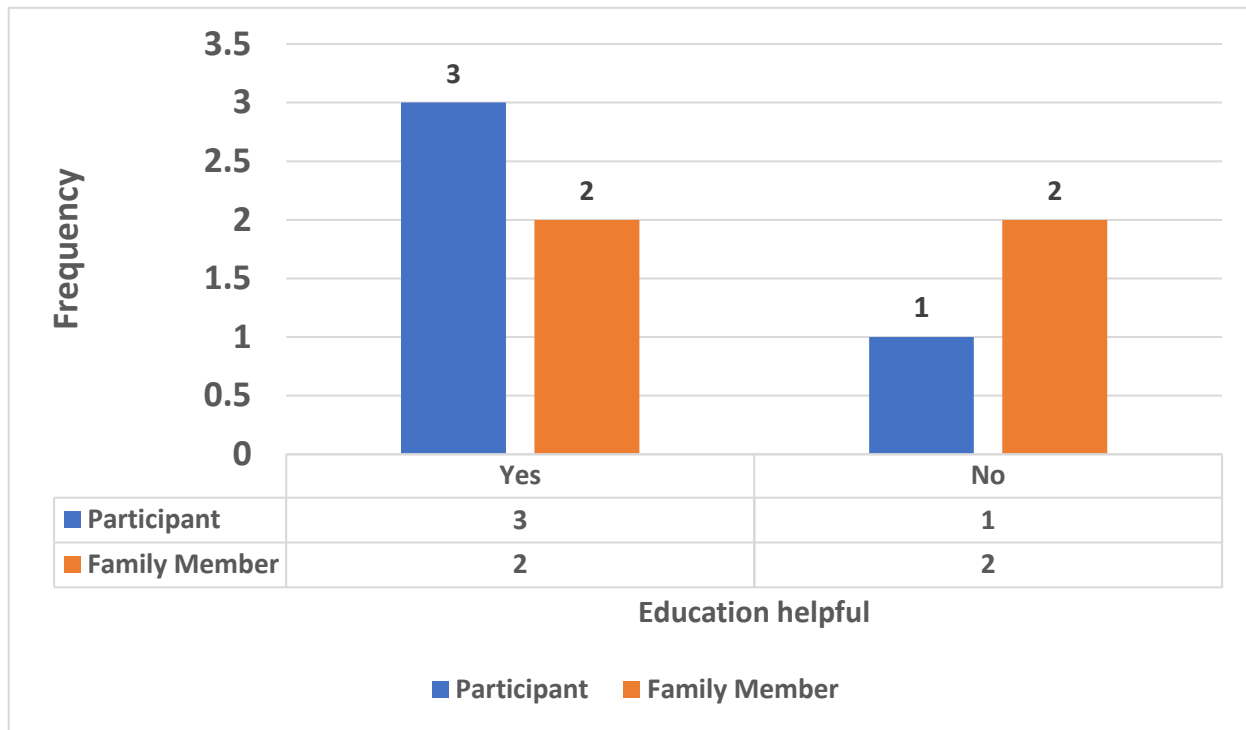


Figure 12

Was the Education Culturally Tailored to Dietary Needs

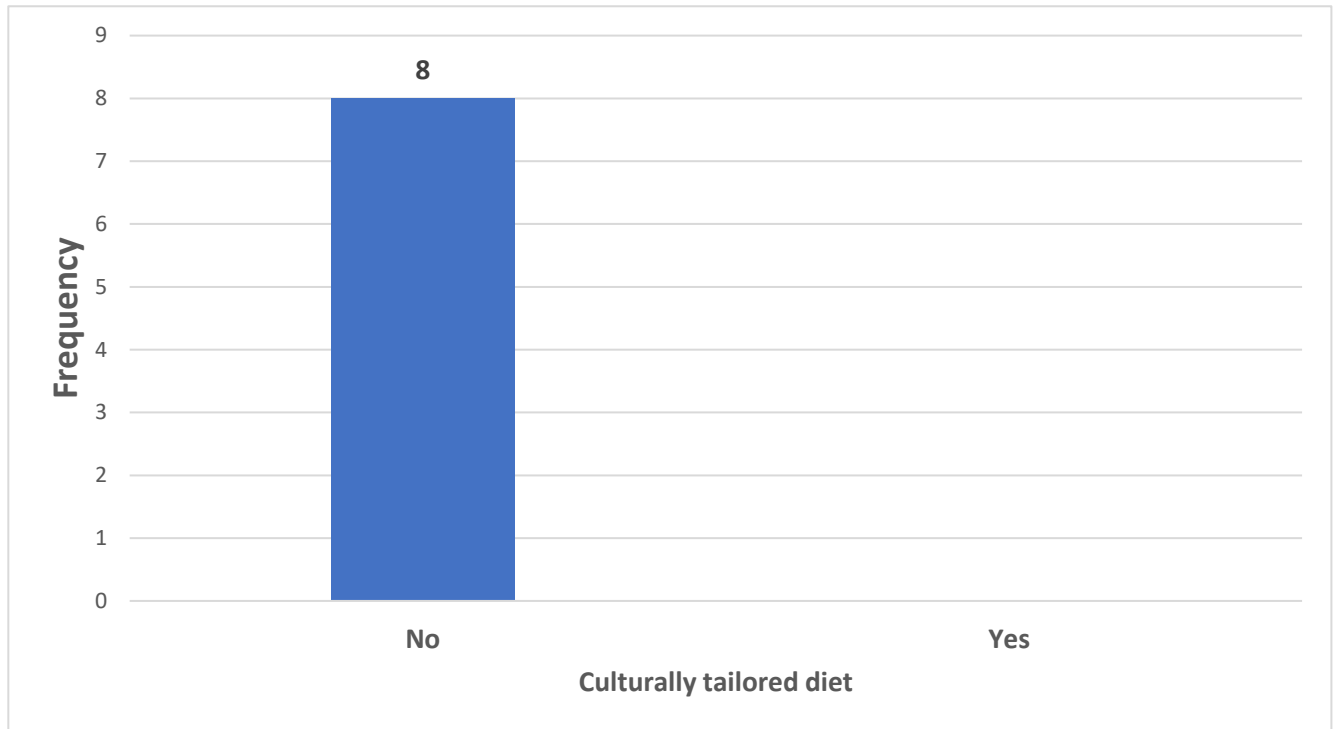


Figure 13

Feeling After Negative Encounters with Healthcare Providers

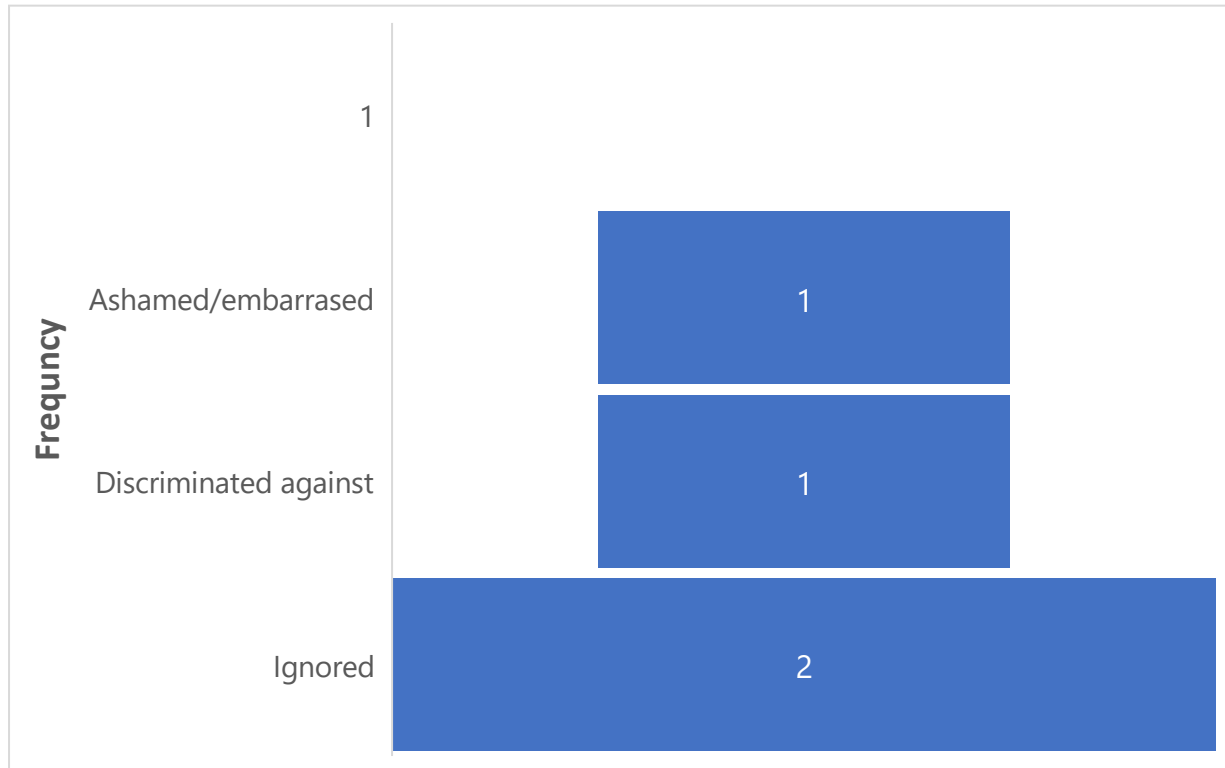


Figure 14

Black Church Attendance

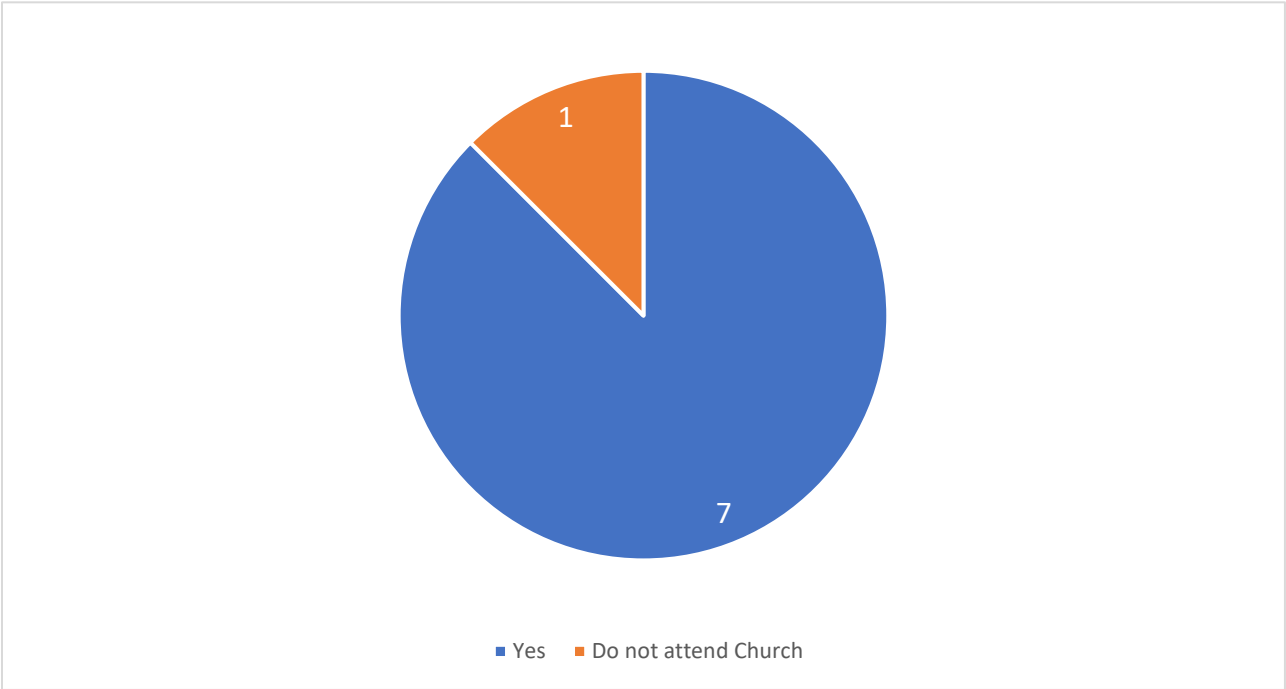


Figure 15

Comfort Attending Diabetes Forum at Church



Figure 16

Reasons for Comfort Attending Diabetes Forum at Church

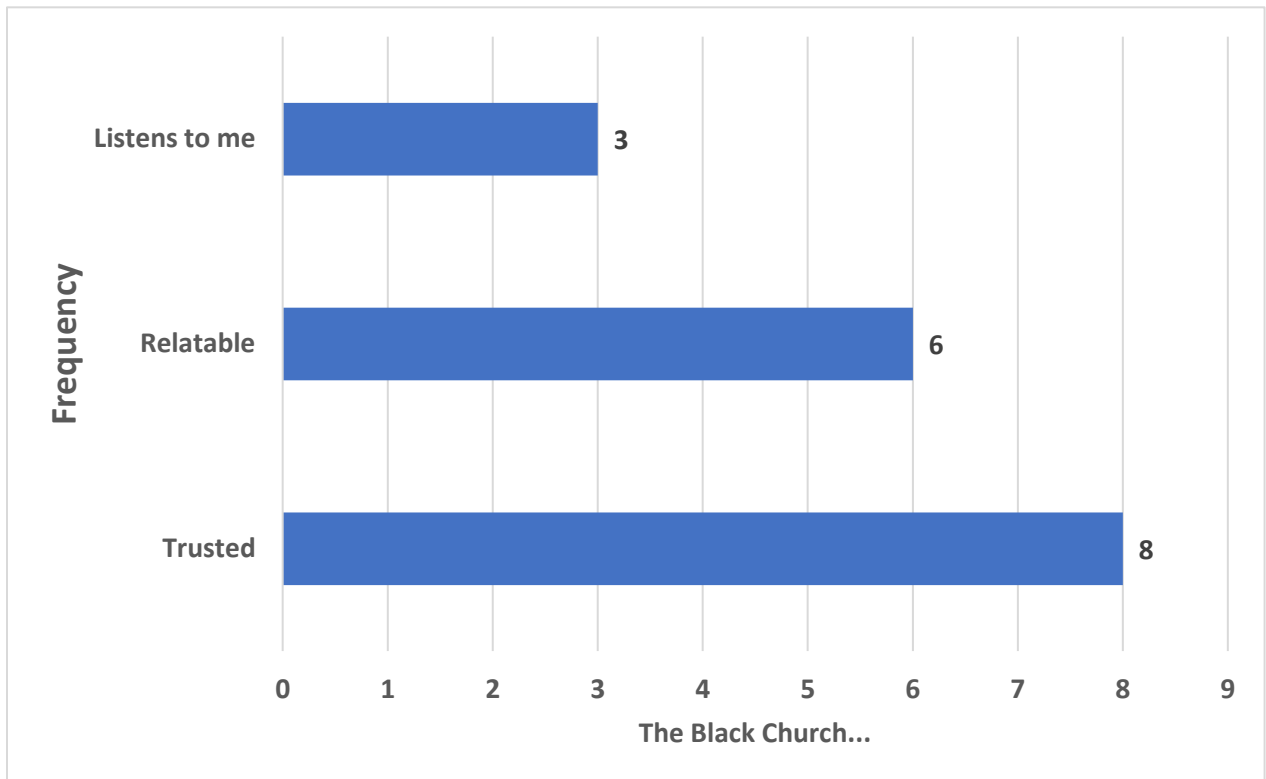


Figure 17

Participant Age

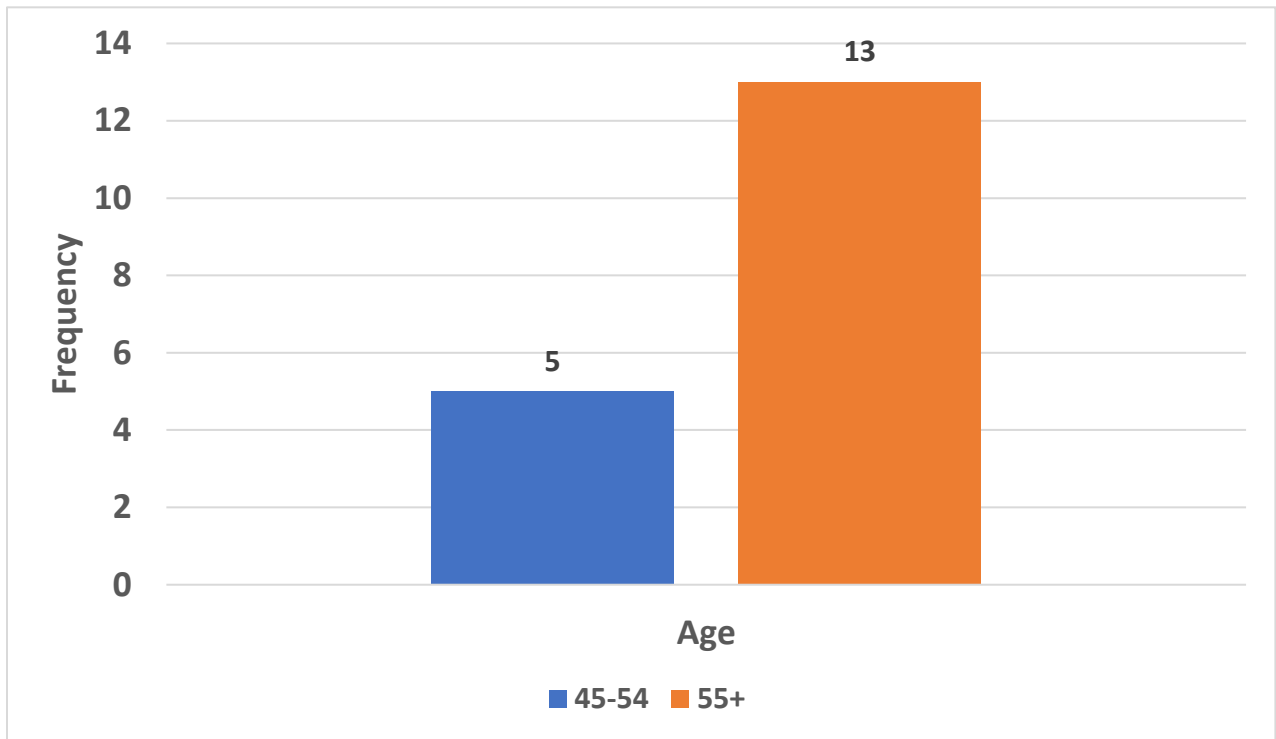


Figure 18

Participant Gender

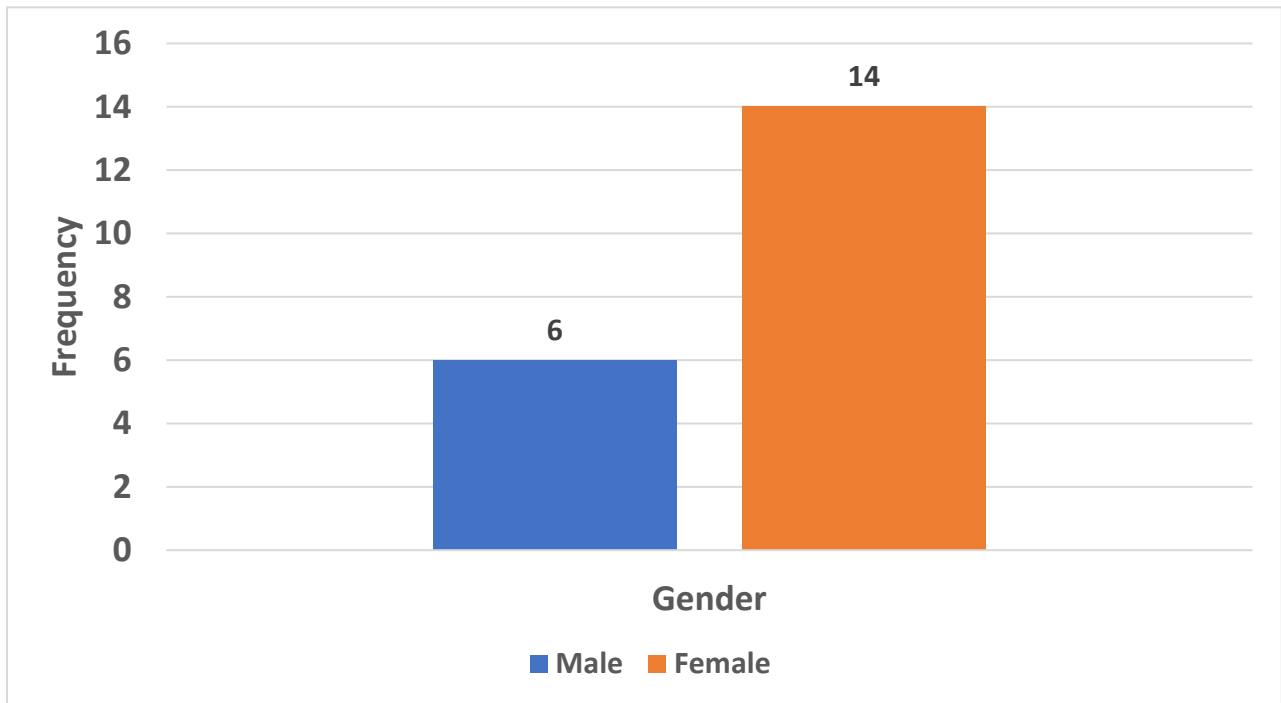


Figure 19

Participant Race and Ethnicity

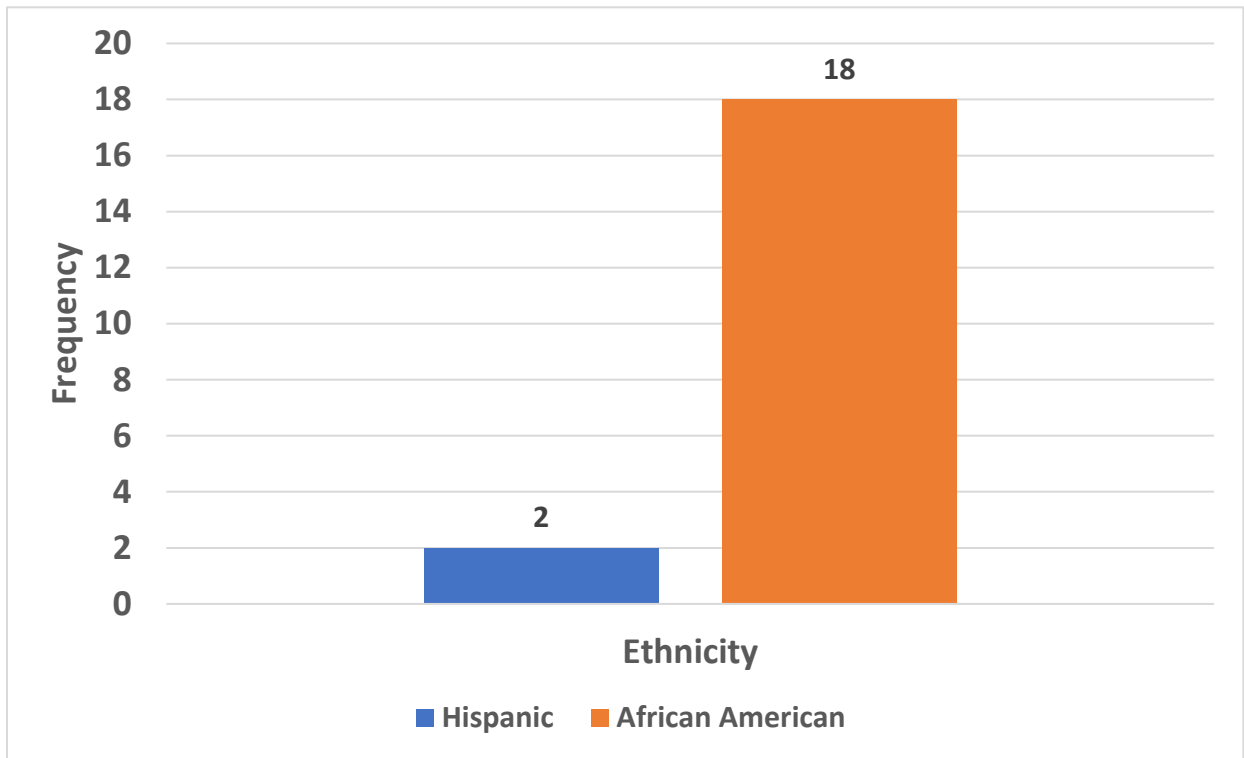


Figure 20

Participant Marital Status

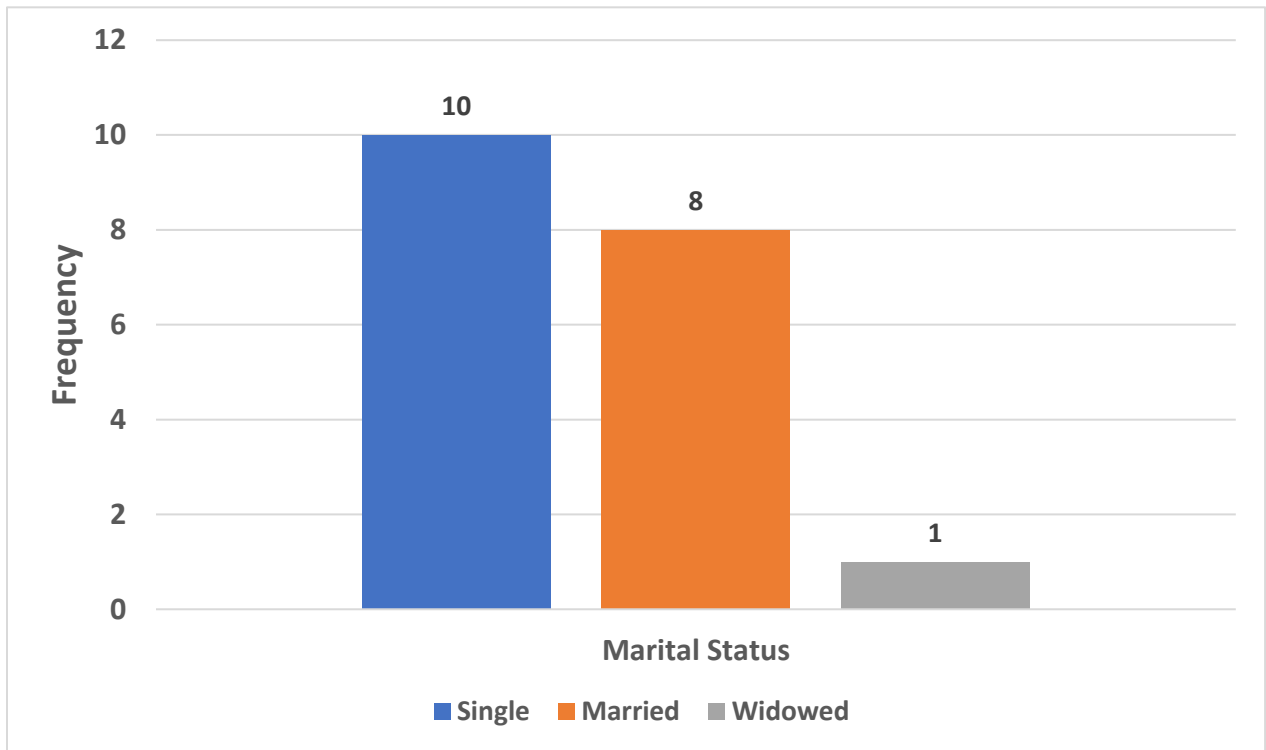


Figure 21

Attendance at Black Church

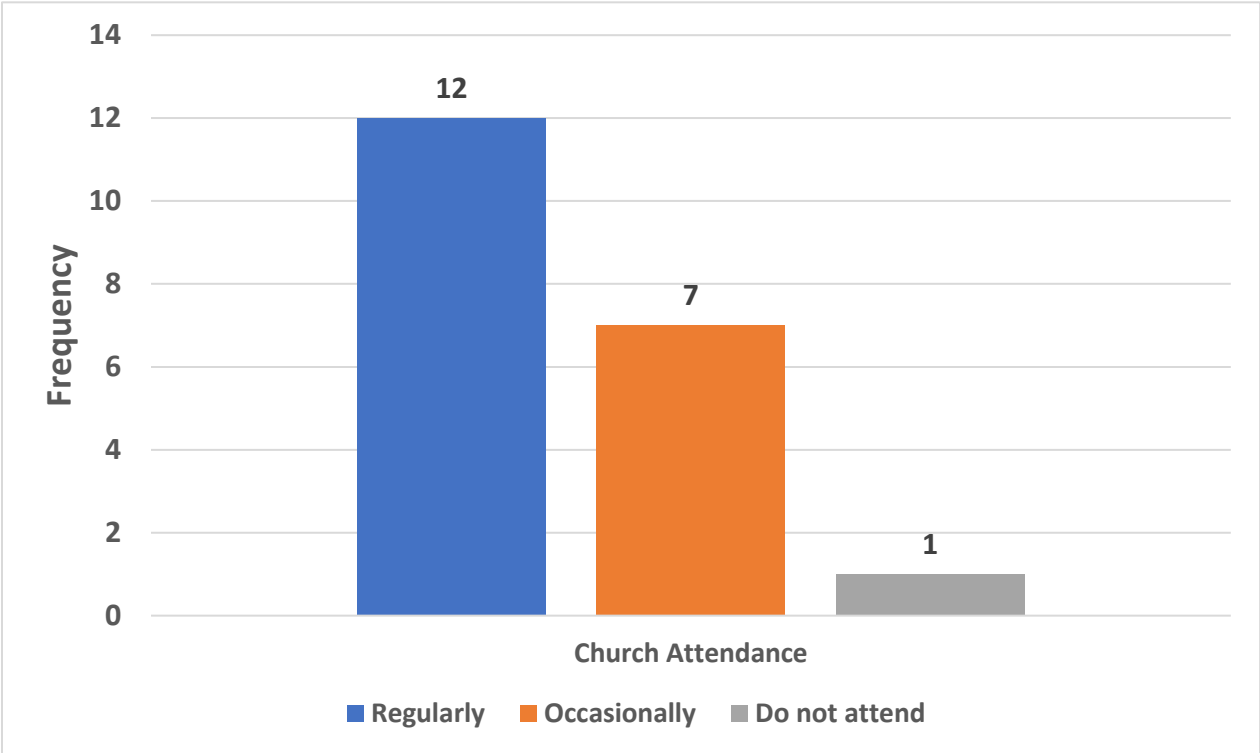


Figure 22

Participant Diabetes Status

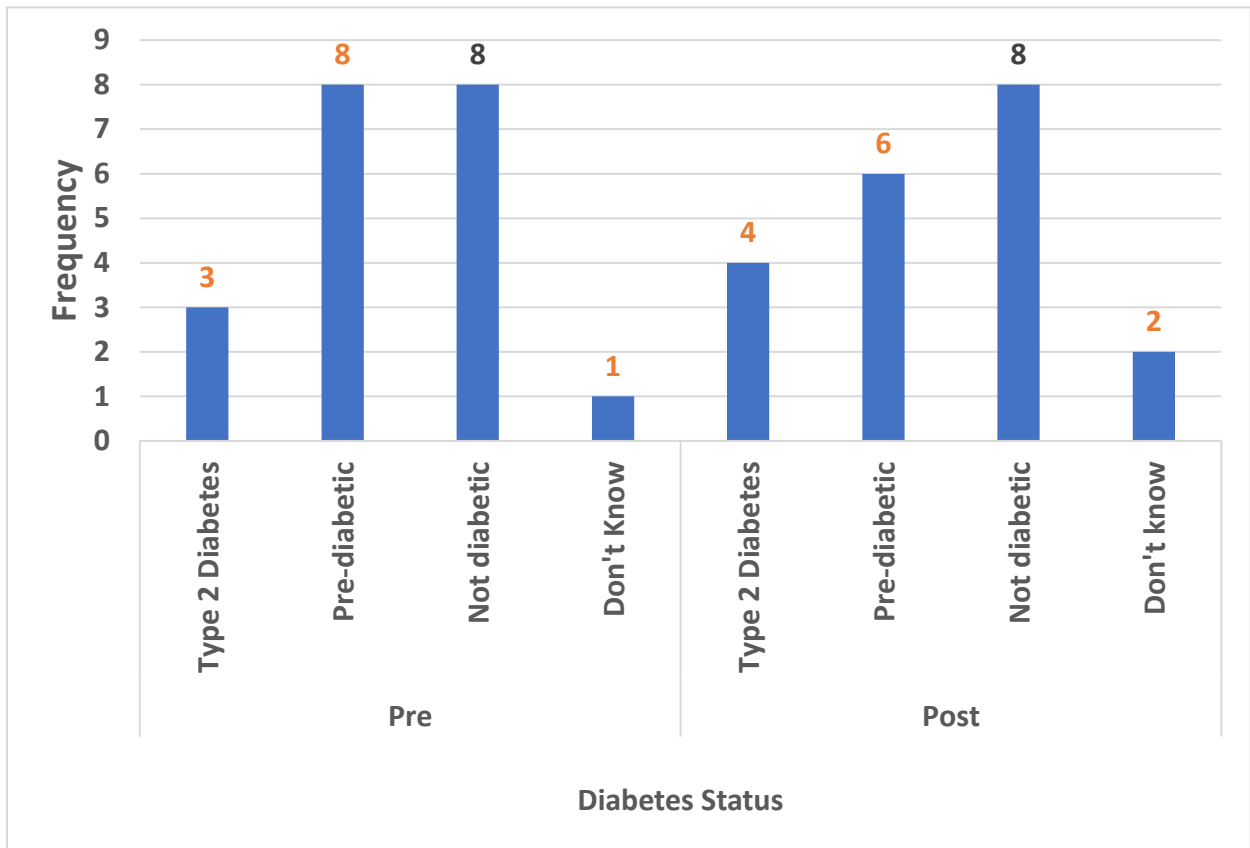


Figure 23

Understanding of Diabetes

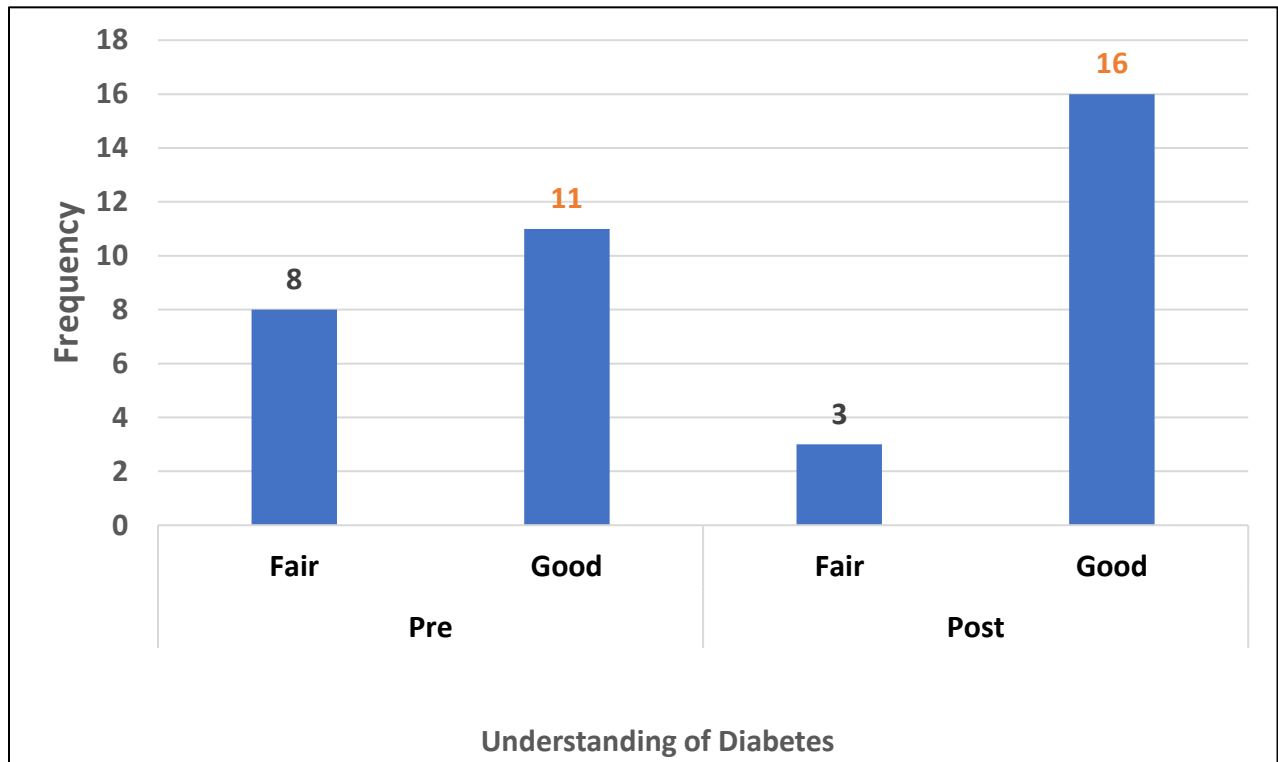


Figure 24

Diabetes as a Severe Health Condition

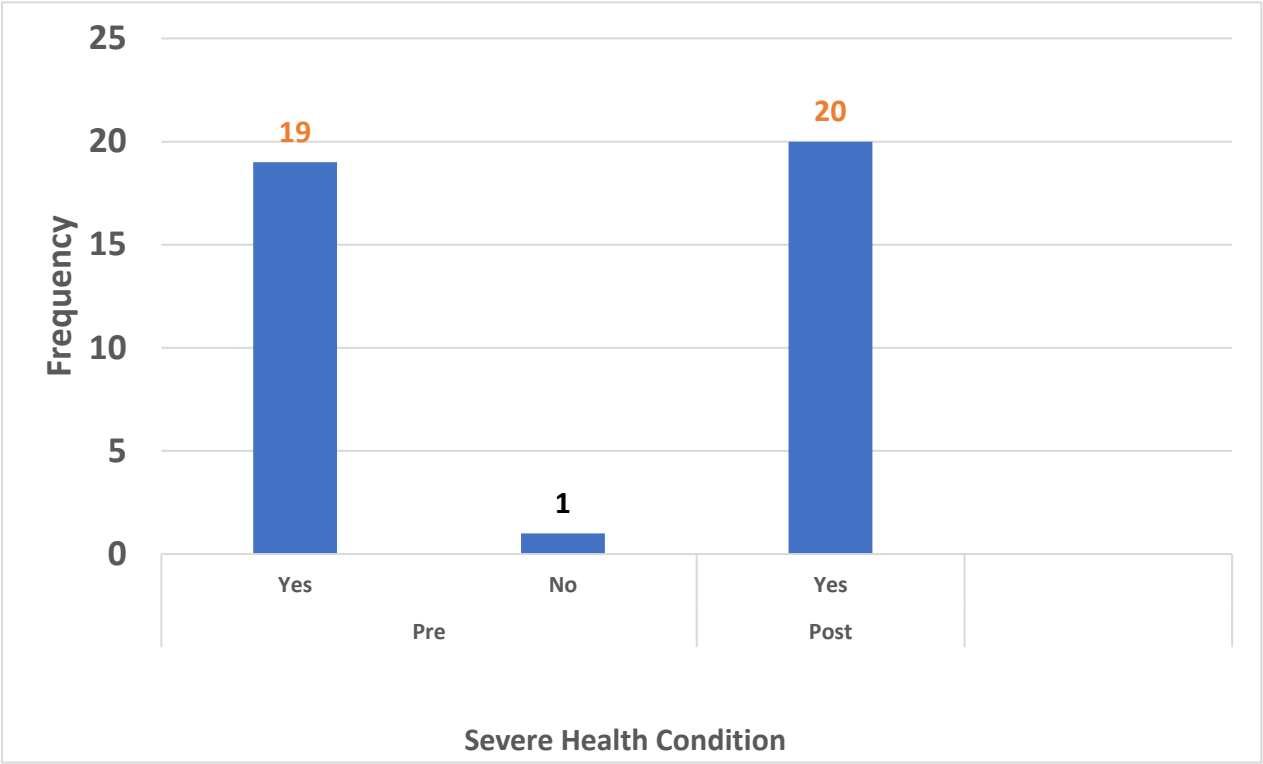


Figure 25

Diet as an Essential Factor in Managing Diabetes

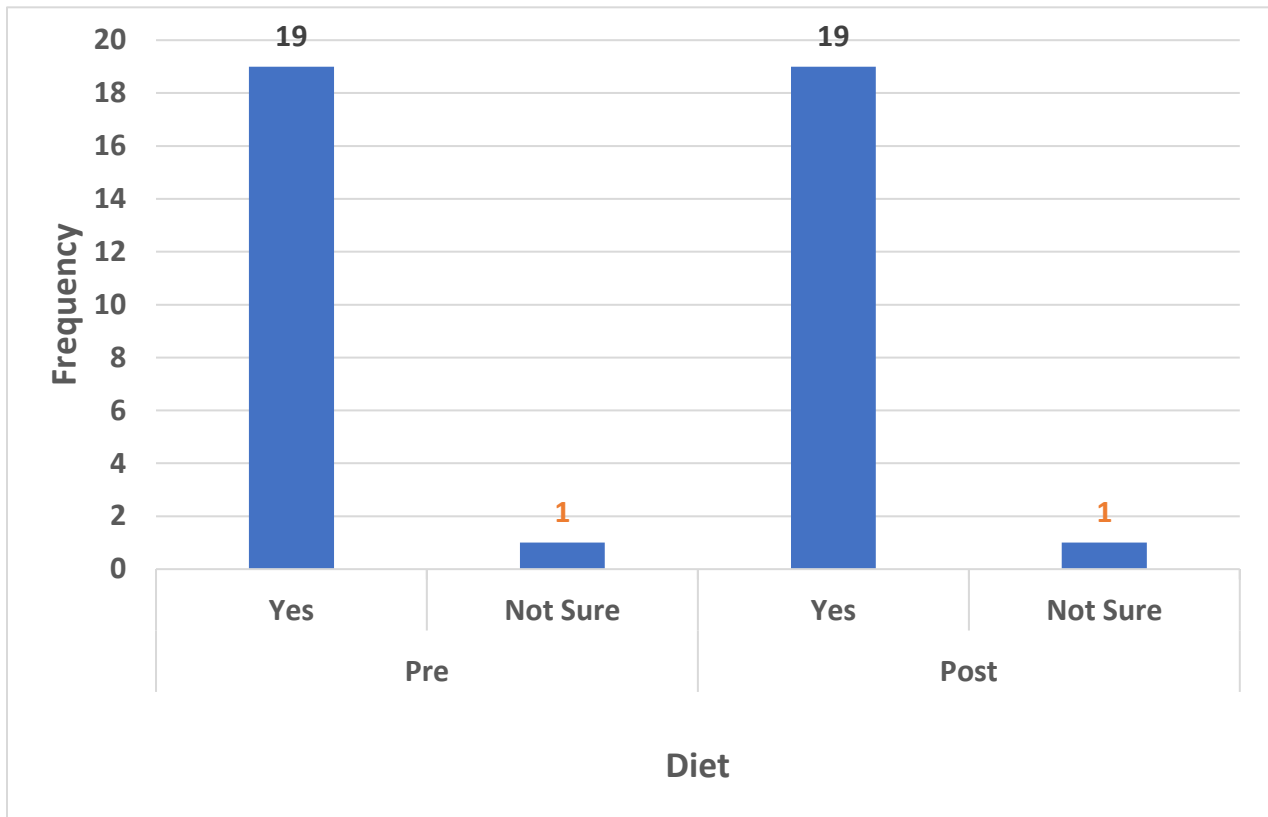


Figure 26

Culturally Tailored Diabetes Education for African Americans Can Promote Better Health

Outcomes

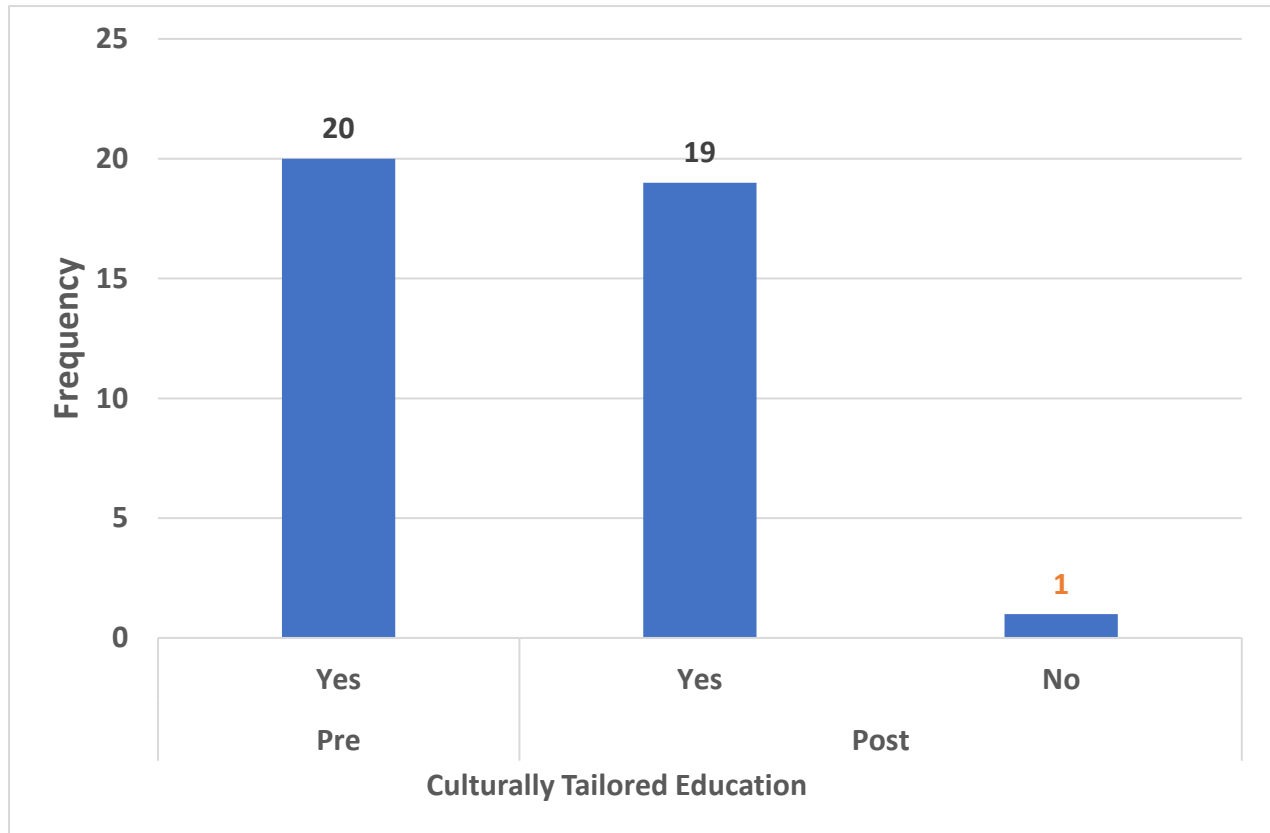


Figure 27

Having a Voice in Diabetes Treatment Plan Motivates Lifestyle Changes

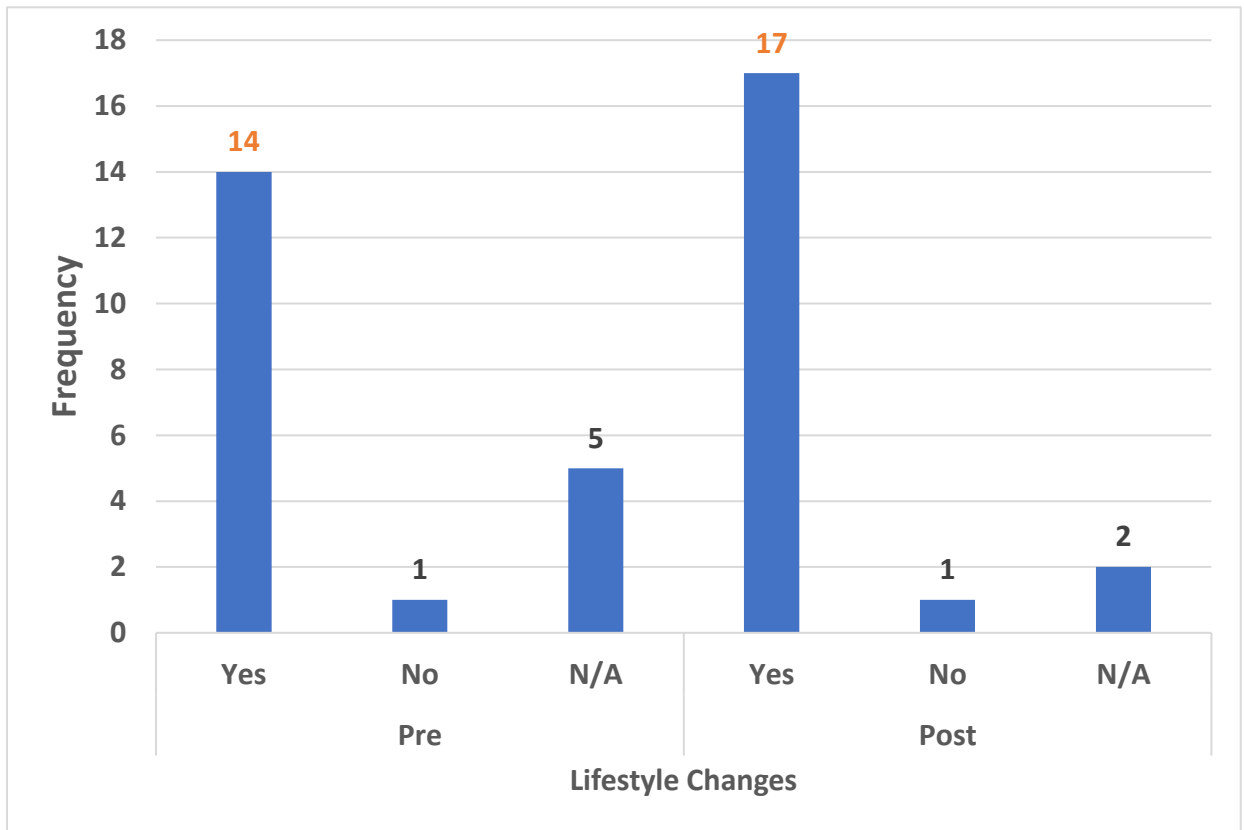


Figure 28

Ability to Take Control of Diabetes Health and Make Positive Changes

