Abstract

**Background and Purpose:** Diabetes care among underserved older adults is negatively impacted by social determinants of health (SDOH). One in five older adults with diabetes mellitus (DM) at the project site has poorly controlled disease, largely due to their limited ability to participate in routine clinical management. The Diabetes COACH TeAM project aims to bridge the existing gap in diabetes care by integrating evidence-based telemedicine and community health worker (CHW) interventions.

**Methods:** This quality improvement project utilized a pre-post intervention design. Participants were composed of adults aged ≥65 years with uncontrolled DM type 1 or 2 from a Federally Qualified Health Center in southwest Ohio. The interventions involved bi-weekly CHW home visits and diabetes self-management education for 12 weeks. The CHWs conducted SDOH assessments and basic education, and facilitated same-day telemedicine appointments with the clinical team to reinforce disease management. The outcomes of interest included A1C values, diabetes self-care activities, diabetes knowledge, and patient and provider satisfaction levels.

**Results:** A total of 11 patients completed the project. The A1C levels and diabetes knowledge of older adults significantly improved after three months. However, there were no statistically significant changes in diabetes self-care activities. The CHWs addressed the SDOH common to older adults, whereas telemedicine improved the communication between the patients and their care team. The patients and staff were highly satisfied with the project interventions.

**Conclusions & Implications:** This project delivered patient-centered and equitable diabetes care services that were previously unavailable to the underserved older patients, while demonstrably improving outcomes. Future research is needed to evaluate the cost-effectiveness, long-term impact, and sustainability of the project in other primary care settings.
Keywords: diabetes; aged; community health workers; telemedicine.