Objective: Type 2 diabetes is more prevalent and severe among African Americans than among Whites. To elucidate barriers to glucose control that are unique to African Americans with poor glucose control we conducted a qualitative study among veterans with diabetes in an academic Veterans Affairs medical center.

Methods: We enrolled African American and White veterans with diabetes; participants’ glucose control was described as well controlled or poorly controlled, and groups were organized on the basis of ethnicity and glucose control. Discussions were conducted by using modified nominal group technique to define factors that aided or hindered glucose control.

Results: Well-controlled groups similarly reported that self-care, health care, and psychosocial factors were important in controlling glucose. Although poorly controlled African Americans cited self-care as important, they also noted difficulty following self-care practices and the interference of psychosocial factors with glucose control. Poorly controlled Whites were similar. Uniquely, poorly controlled African Americans were less likely to report positive healthcare experiences; their barriers were related to poor access and poor relationships with providers.

Conclusions: Poorly controlled African Americans endorsed healthy self-care behaviors but found it difficult to follow through. Interventions targeting the management of stress, depression, mood, and temptation, as well as improved access to and communication with providers may help these patients better manage their glucose and minimize disparities in diabetes outcomes. (Ethn Dis. 2009;19:121–127)

Key Words: Diabetes Mellitus, African Americans, Blood Glucose, Health Status Disparities, Veterans

INTRODUCTION

African Americans are disproportionately affected by the type 2 diabetes epidemic in the United States. Compared with Whites, African Americans have worse glucose control and higher rates of microvascular complications associated with diabetes, which are strongly linked to glucose control. Disparities in glucose control exist even within the Veterans Health Administration (VHA), which is thought to minimize barriers in access to care.

Large-scale quality improvement initiatives have reduced disparities in process measures; however, 2 recent evaluations of such initiatives in health maintenance organizations have shown that despite the improvement in process measures, disparities in glucose control persist and may have widened. Specifically within the VHA, quality improvement initiatives have led to improved processes of care and have reduced racial disparities in care provided. However, disparities persist in diabetes outcomes, which suggests that reducing racial disparities in glucose control may require a more focused approach. Recent community-based interventions show potential as a means to improving glucose control in low-income minority communities; however, for providers such as the VHA, community-based interventions may not be useful since their patient population is not neighborhood-based.

Racially tailored interventions may help eliminate disparities in glucose control, especially within the VHA and other non–community-based healthcare providers. However, appropriate targets must be identified for these interventions. Qualitative research is useful in addressing persistent gaps in knowledge and in exploring individual-level characteristics, unique to a specific population. Among African Americans, qualitative research has been used successfully to elucidate factors relating to glucose control, including family support, problem solving, and fatalism. However, no prior study has employed qualitative methods to compare barriers to glucose control across race groups.

To identify potential targets for intervention, we performed a qualitative study of African American and White veterans with diabetes. Our objective was to identify barriers to good glucose control among African American veterans with poorly controlled diabetes to understand how these barriers differ from those faced by African Americans with good glucose control and Whites with both poor and good glucose control.

METHODS

Participants

We identified potential participants by using Philadelphia VA Medical Center (PVAMC) administrative databases, identifying veterans with a diagnosis code consistent with diabetes and a pharmacy code for a hypoglycemic medication within the past year. We then reviewed laboratory data to determine glucose control. Good control was defined as having a glycosylated hemoglobin (HbA1C) level ≤7% on 2 occasions 9 months apart during the last 18 months. Poor control was defined as HbA1C level ≥9% on 2 occasions during the last 18 months. Invitations to participate in the study were sent by mail and followed with a