

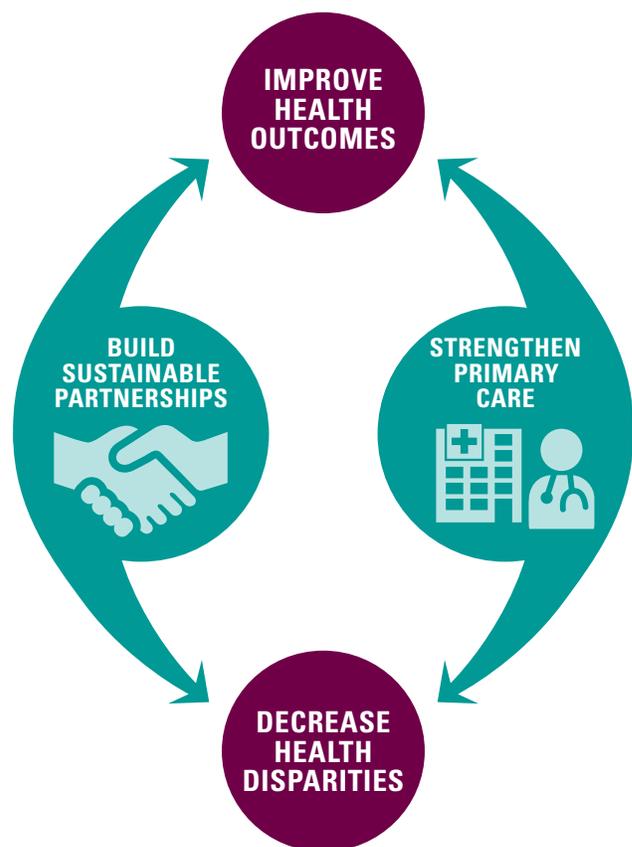


BRIDGING THE GAP: REDUCING DISPARITIES IN DIABETES CARE

An estimated **30 million Americans live with diabetes** – about 9% of the population.¹

Vulnerable and underserved populations are more likely to have diabetes and often experience barriers to effectively managing the disease, increasing their risk of serious complications and further widening disparities in health outcomes.^{1,2,3} Promoting health equity among people with diabetes requires a comprehensive approach that integrates high-quality health services with resources drawn from outside the health system.

To advance cross-sector approaches that improve diabetes outcomes, the **Merck Foundation** (the Foundation) established *Bridging the Gap: Reducing Disparities in Diabetes Care* (*Bridging the Gap*) with a \$16 million, five-year commitment. *Bridging the Gap* is a multi-site initiative that aims to increase access to high-quality diabetes care and reduce disparities in health outcomes for vulnerable and underserved populations with type 2 diabetes in the United States.



BRIDGING THE GAP PROGRAM PARTNERS

Bridging the Gap program partners across the United States are implementing comprehensive, evidence-based programs that transform primary care to improve the delivery of diabetes care. The program partners are building partnerships between the health care sector and other sectors to address the **social determinants of health** – the social and environmental factors that affect health. Through these multi-sector collaborations, people living with diabetes can benefit not only from better medical care, but also from efforts that will help them lead healthier lives.

To address the social determinants of health, *Bridging the Gap* program partners collaborate with diverse local organizations to connect people with diabetes to resources in their communities that provide access to nutritious foods, safe options for physical activity, affordable housing, employment support, legal services, and transportation.



★ **The University of Chicago (Chicago, IL)** serves as the National Program Office for *Bridging the Gap*. The University of Chicago supports program efforts of the grantee organizations and provides leadership in building a national public-private partnership to help reduce disparities in diabetes care.

PROGRAMS AT A GLANCE

Alameda County Public Health Department, Oakland, CA

Alameda County Public Health Department aims to improve care and reduce diabetes-related hospitalizations among low-income African Americans and Latinos living in East Oakland, Hayward, Ashland, and Cherryland.

The program is transforming the delivery of diabetes care by integrating peer educators, community health workers (CHWs) and patient navigators into care teams and training them to help patients develop individualized diabetes management action plans. The Health Department offers social support for people with diabetes by arranging group medical appointments and referring them to services that promote access to healthy food, physical activity, and address other needs such as housing, public benefits, and employment.

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Clearwater Valley and St. Mary's Hospitals and Clinics, Orofino, ID

Clearwater Valley and St. Mary's Hospitals and Clinics work to strengthen the quality of care and address the social determinants of health for low-income people with diabetes who live in sparsely populated and geographically isolated areas.

The program integrates behavioral health workers and CHWs into patient-centered medical home teams to better coordinate care and connect people with diabetes to community resources for social support. The organization partners with other health care and social service agencies to comprehensively address both medical and social factors relating to health.

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La Clínica del Pueblo, Washington, DC

La Clínica del Pueblo aims to achieve better health outcomes for low-income, Latino immigrants by providing access to high-quality diabetes care that is culturally and linguistically appropriate.

The program provides care coordination tailored to the needs of the patient population and care teams include CHWs who are equipped to provide culturally-relevant services. The program educates patients about managing their diabetes and facilitates provider-patient communication using digital technology. La Clínica del Pueblo collaborates with community organizations that offer access to healthy food and green spaces for physical activity. The organization also partners with legal service providers to address immigration-related legal needs of Latinos with diabetes.

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Marshall University, Huntington, WV

Marshall University is working to establish a system that fosters collaboration between local health clinics and community resources to better serve people with diabetes from rural communities in West Virginia, Kentucky, and Ohio who have limited access to care.

The program is implementing a sustainable care coordination model that includes CHWs on the care team who conduct home visits and connect people with diabetes to community services that address the social determinants of health. The University is also exploring, with the Center for Health Law & Policy Innovation at Harvard University, options for financing this model in a sustainable way.

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Minneapolis Health Department, Minneapolis, MN

The Minneapolis Health Department aims to enhance the delivery of diabetes care and increase patient engagement among low-income African Americans, Native Americans and Latinos with diabetes who are at high risk for diabetes-related complications.

The program offers home visits and utilizes digital technology to better coordinate care for vulnerable populations. The Health Department also integrates CHWs into care teams to educate people with diabetes about self-management of the disease and link them to community resources for healthy food, physical activity, and self-management support.

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Providence St. Joseph Health, Portland, OR

Providence St. Joseph Health works to improve care, reduce health disparities, and strengthen coordination between clinical and social services at three local clinics that serve many low-income individuals with diabetes.

The program identifies gaps in care and then deploys multidisciplinary teams to address them. The target clinics embed full-time community resource specialists who are multilingual and multicultural; they are also trained in motivational interviewing and trauma-informed care to provide referrals to local resources, social services, and benefit programs. In addition, the organization conducts outreach to community residents who are at risk of diabetes or may have unmet diabetes-related health needs.

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Trenton Health Team, Trenton, NJ

Trenton Health Team's Capital City Diabetes Collaborative is working to improve care and health outcomes among vulnerable, low-income populations through a city-wide, comprehensive approach to diabetes care tailored to individual patient needs.

The Collaborative uses culturally-relevant materials to educate patients about managing their diabetes and offers peer support and mentoring, both in-person and through a multi-media technology platform. The Collaborative also works closely with local organizations to help increase patients' access to healthy food through meal delivery, community gardens, farmers markets, and soup kitchens.

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Western Maryland Health System, Cumberland, MD

Western Maryland Health System aims to transform primary care for low-income, rural populations with diabetes who often face geographic barriers to care.

To reach this population, the program embeds diabetes care managers in primary care practices. The program also involves community paramedics who conduct home visits, uses telemonitoring to promote communication between vulnerable patients and care providers, and offers education on diabetes self-management that is culturally appropriate. The organization fosters community partnerships to facilitate access to healthy food and provides referrals to local resources that can address needs related to housing, health insurance coverage, or transportation.

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Advancing Best Practices in Cross-Sector Collaboration

The Foundation will assess the impact of *Bridging the Gap* through an independent cross-site evaluation. A key goal will be to identify and promote best practices in primary care transformation and innovative multi-sectoral strategies that advance health equity among vulnerable and underserved populations with diabetes.

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