FREQUENTLY ASKED QUESTIONS

WHAT IS THE GOAL OF THE MERCK FOUNDATION BRIDGING THE GAP: REDUCING DISPARITIES IN DIABETES CARE INITIATIVE?

The goal of this initiative is to improve access to high-quality diabetes care and reduce health disparities among vulnerable and underserved populations with type 2 diabetes in the United States. The Merck Foundation is committing $16 million over five years to support Bridging the Gap and its program partners in selected communities across the country.

WHY FOCUS ON THE TRENTON COMMUNITY?

Within the six zip codes of Trenton, 31% of adults have hypertension, and 16% have diabetes, compared with approximately 9% for Mercer County, NJ, and the United States. There are more than 5,000 Medicaid beneficiaries with diabetes in the Trenton community.

WHY IS THE TRENTON HEALTH TEAM (THT) LEADING THIS EFFORT IN TRENTON?

Diabetes is one of the most prevalent chronic conditions among our residents and has therefore been a central focus of many of THT's efforts. Trenton has implemented innovative approaches to diabetes care by addressing the health care, social, and environmental barriers that exist for residents in our geography.

HOW MUCH FUNDING WILL THE TRENTON HEALTH TEAM RECEIVE AS PROGRAM GRANTEE OF THE MERCK FOUNDATION BRIDGING THE GAP INITIATIVE?

Trenton Health Team has been awarded a grant from the Merck Foundation for a total of $1.5 million over five years.

WHAT ARE THE GOALS OF THE TRENTON PROJECT?

The Capital Cities Diabetes Collaborative was launched to improve health outcomes of Trenton residents with diabetes, increase patient engagement and self-management of their disease and improve the availability of healthy foods for Trenton residents. Our program goals and objectives fall into three general areas:

- To improve health outcomes for Trenton residents with diabetes
- To increase patient engagement and self-management of their disease
- To improve the availability of healthy foods and lifestyle options for Trenton residents.

WHAT IS THE VISION FOR THE CAPITAL CITY DIABETES COLLABORATIVE?

Our Capital City Diabetes Collaborative will move our vision of a citywide, evidence-based system to reality. Using the Trenton Health Information Exchange, we will create a unified and consistent approach across the city. This collaborative, technology-driven framework will allow ongoing program monitoring and serve as a foundation for innovation.

HOW WILL TRENTON RESIDENTS BENEFIT FROM THE PROGRAM?

Our project will serve adult residents of the Trenton community (18+ years of age) who are diagnosed with type 2 diabetes. Of particular and immediate focus will be Medicaid beneficiaries who have been identified through the Trenton Health Information Exchange as diabetic –5,275 Medicaid diabetics as of March 2017. We expect this number to grow with improved screening and referrals. Our initiative will take a multi-faceted approach to accomplishing the project goals, including:

- Improve the quality of care for adults with type-2 diabetes and comorbid hypertension and hyperlipidemia
- Decrease diabetes-related health disparities by identifying and targeting groups that are among the highest levels of diabetes-related disparities: low-income, minority individuals with behavioral health co-morbidities
- Build sustainable partnerships across health care delivery organizations and other agencies that address the medical and social determinants of health.

WHAT PARTNER ORGANIZATIONS WILL THT WORK WITH TO ACCOMPLISH THE PROJECT GOALS?

In addition to the city hospitals (Capital Health and St. Francis Medical Center), we will work with the City of Trenton Department of Health and Human Services, Henry J. Austin Health Center, and community and faith-based organizations that will help to address the social determinants of health, including access to healthy food and social services.

HOW WILL THE CAPITAL CITY DIABETES COLLABORATIVE BE EVALUATED?

Local project evaluation will be conducted in collaboration with Montclair State University, through its Center for Research and Evaluation on Education and Human Services (CREEHS). Project staff will work with CREEHS to gather and report pertinent data, review findings, and determine course adjustment if needed. The Trenton HIE will be an important source of clinical data, augmented through surveys and qualitative assessments administered by CREEHS personnel.

WHO ARE THE OTHER PROGRAM GRANTEE ORGANIZATIONSPARTICIPATING IN THE BRIDGING THE GAP INITIATIVE?

Additional program grantees include: Alameda County Public Health Department (Oakland, Calif.); Clearwater Valley Hospital and Clinics (Orofino, Idaho); La Clínica del Pueblo (Washington, D.C.); Marshall University (Huntington, W.Va.); Minneapolis Health Department (Minneapolis, Minn.); Providence St. Joseph Health (Renton, Wash.); and Western Maryland Health System (Cumberland, Md.).