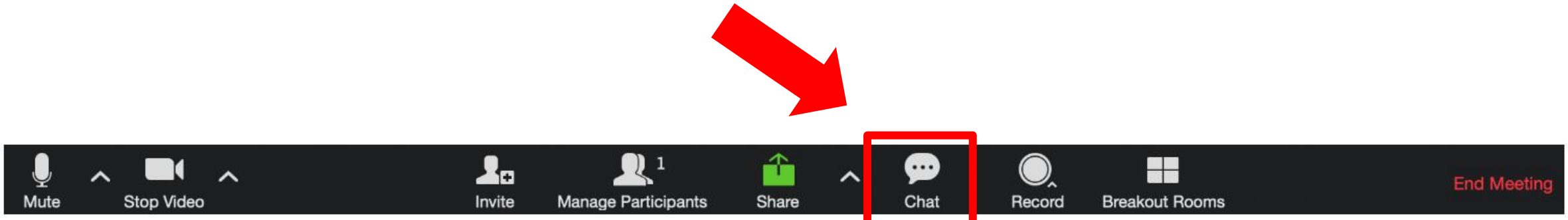
RI DIABETES HEALTH EQUITY CHALLENGE

Supporting the community during the COVID-19 pandemic

Welcome! Please chat in:

- Name and affiliation
- What is something you are proud of doing in service to equity in the context of your COVID-19 response?



RHODE ISLAND DEPARTMENT OF HEALTH

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

100 Million Healthier Lives

WE IN THE WORLD

RI DIABETES HEALTH EQUITY CHALLENGE

Supporting the community during the COVID-19 pandemic

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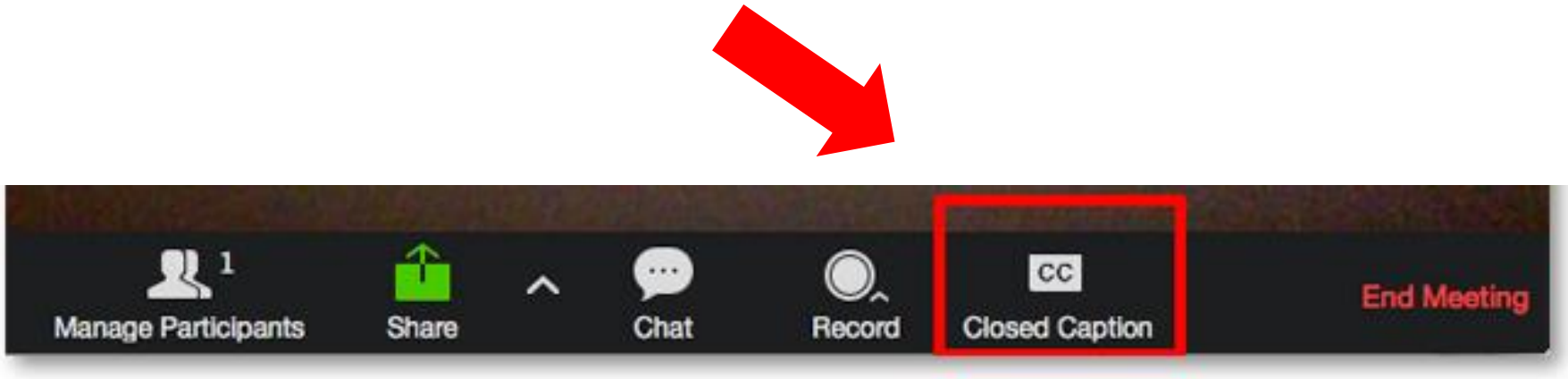

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TODAY'S AGENDA

Teams tell their stories
11:30am – 12:30pm

- Health Equity Challenge Teams present their journey so far
- How Pathways to Population Health tools are being used across the country to address emerging challenges

Health Equity Challenge Teams
12:30 – 1:30pm

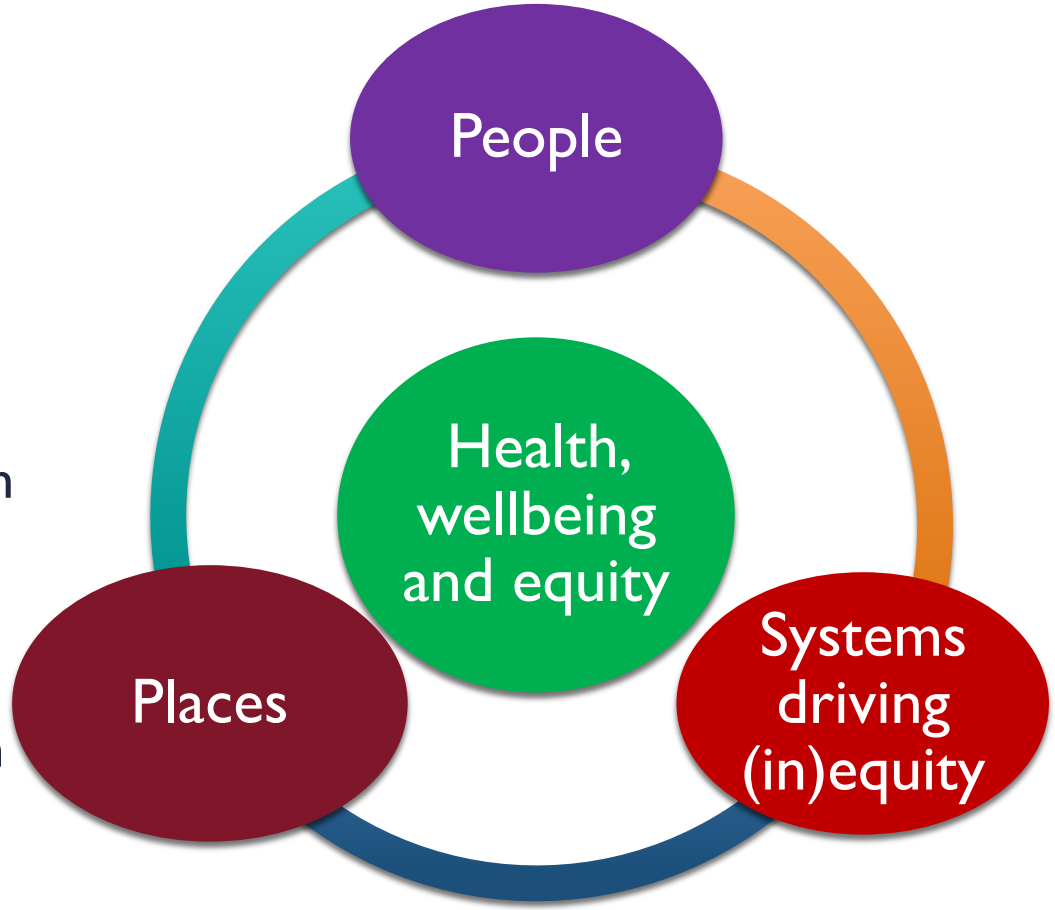
- Set an ambitious equity aims
- Plan for action

KEY CONCEPTS TO IMPROVING POPULATION HEALTH WITH AN EQUITY LENS

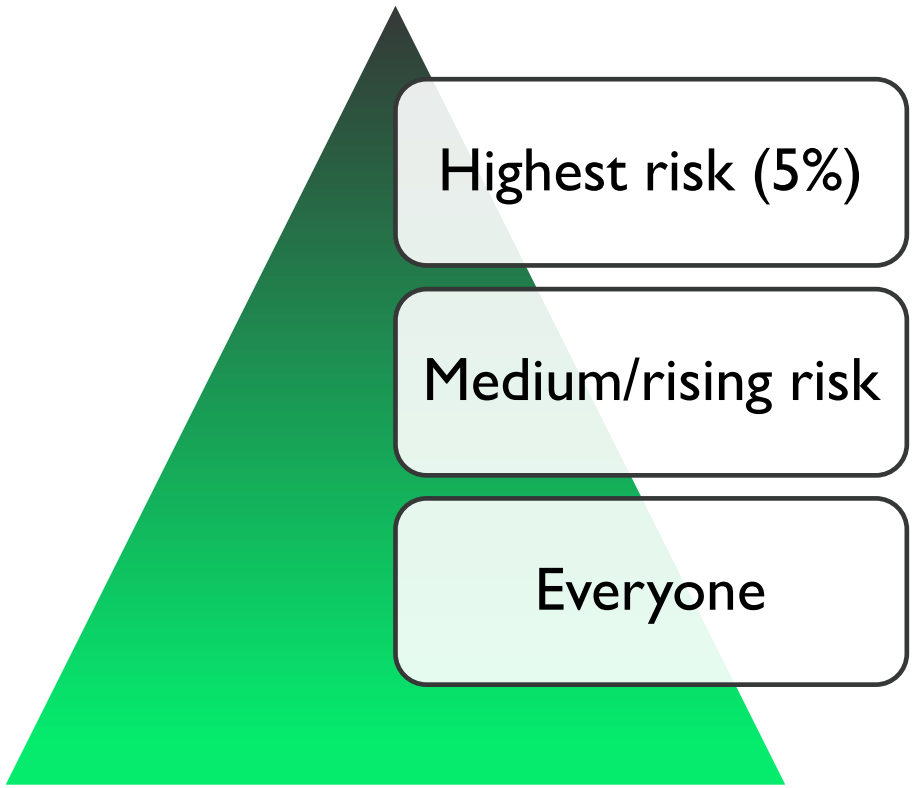
1. The health and well-being of people, places and the systems of society are interconnected.
2. We can learn from the person, plan for the population.
3. To do that, we need to not treat everyone as if they are the same in terms of what they need (population segmentation/risk stratification).
4. We can take action on these together by aligning our assets and using them differently.
5. We need to achieve a balanced portfolio of population health.

IMPROVING POPULATION HEALTH

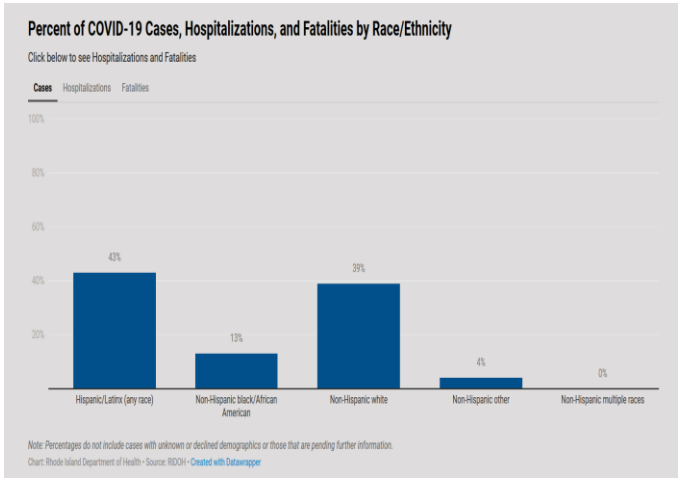
1. Understand that the health and well-being of people, places and the systems of society are interconnected.
2. Stratify and understand the needs of the population, in partnership – who is at risk of not thriving? (think people, places, systems)
3. Achieve a balanced portfolio of population health improvement that meets the needs of the whole person and addresses the underlying conditions in the community that drive poor outcomes
4. Identify focused opportunities to drive strategic improvement even as you change the underlying system
5. Apply a current day and historic equity lens to acknowledge and address root causes.



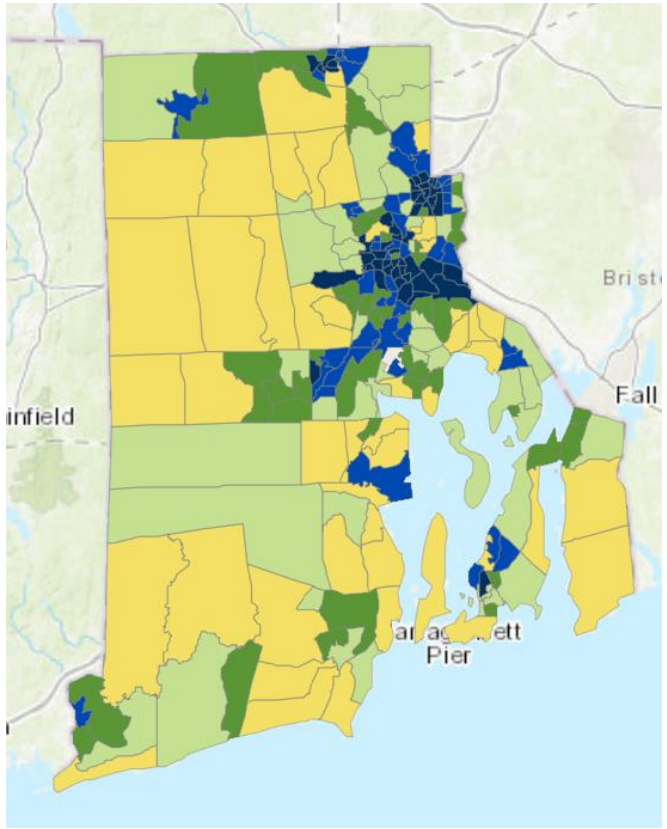
LOOKING AT OUR DATA AND UNDERSTANDING NEEDS BASED ON PEOPLE, PLACES AND SYSTEMS OF INEQUITIES



PEOPLE



INEQUITIES

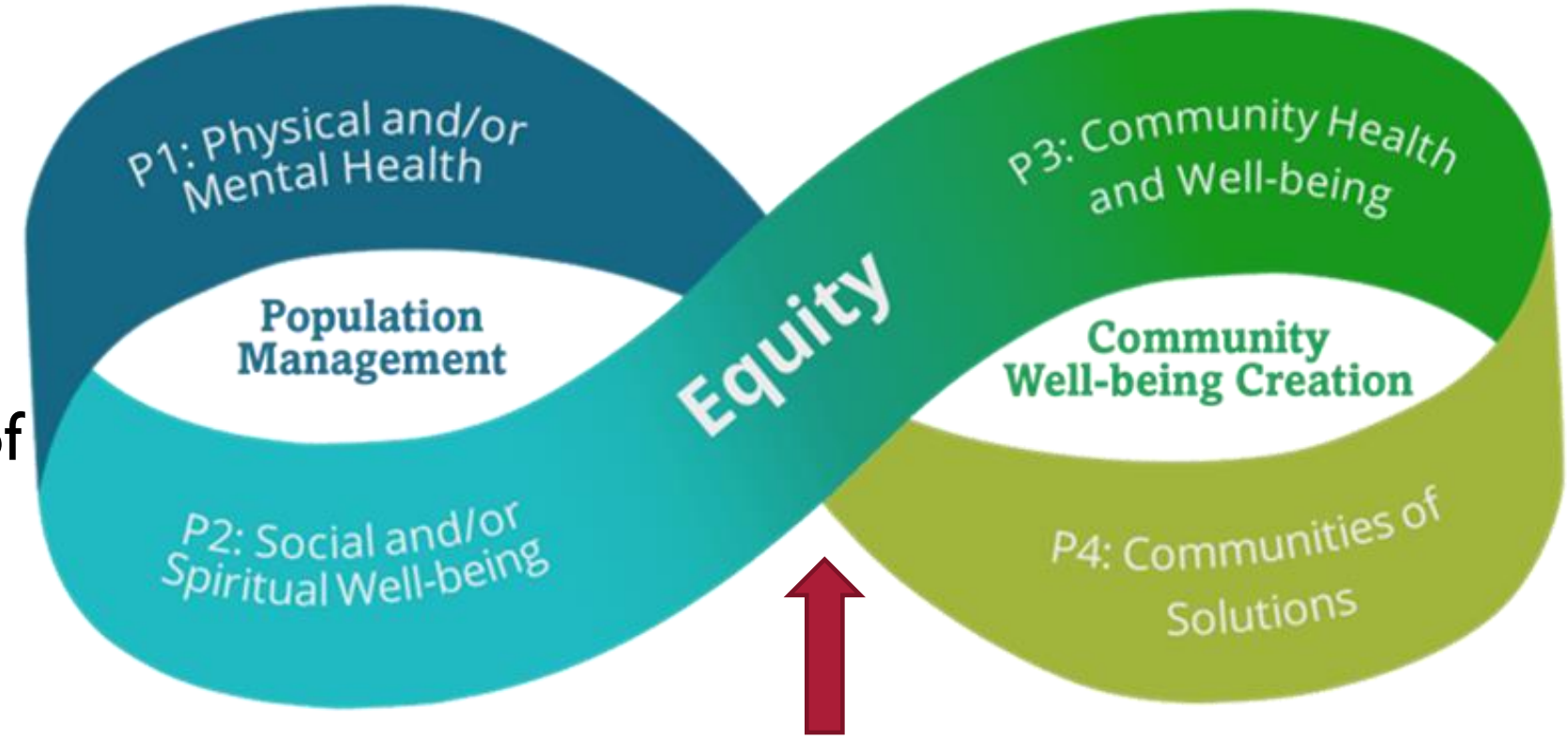


PLACES

FOUR PORTFOLIOS OF POPULATION HEALTH ACTION

PATHWAYS TO POPULATION HEALTH

Improving the health and wellbeing of people



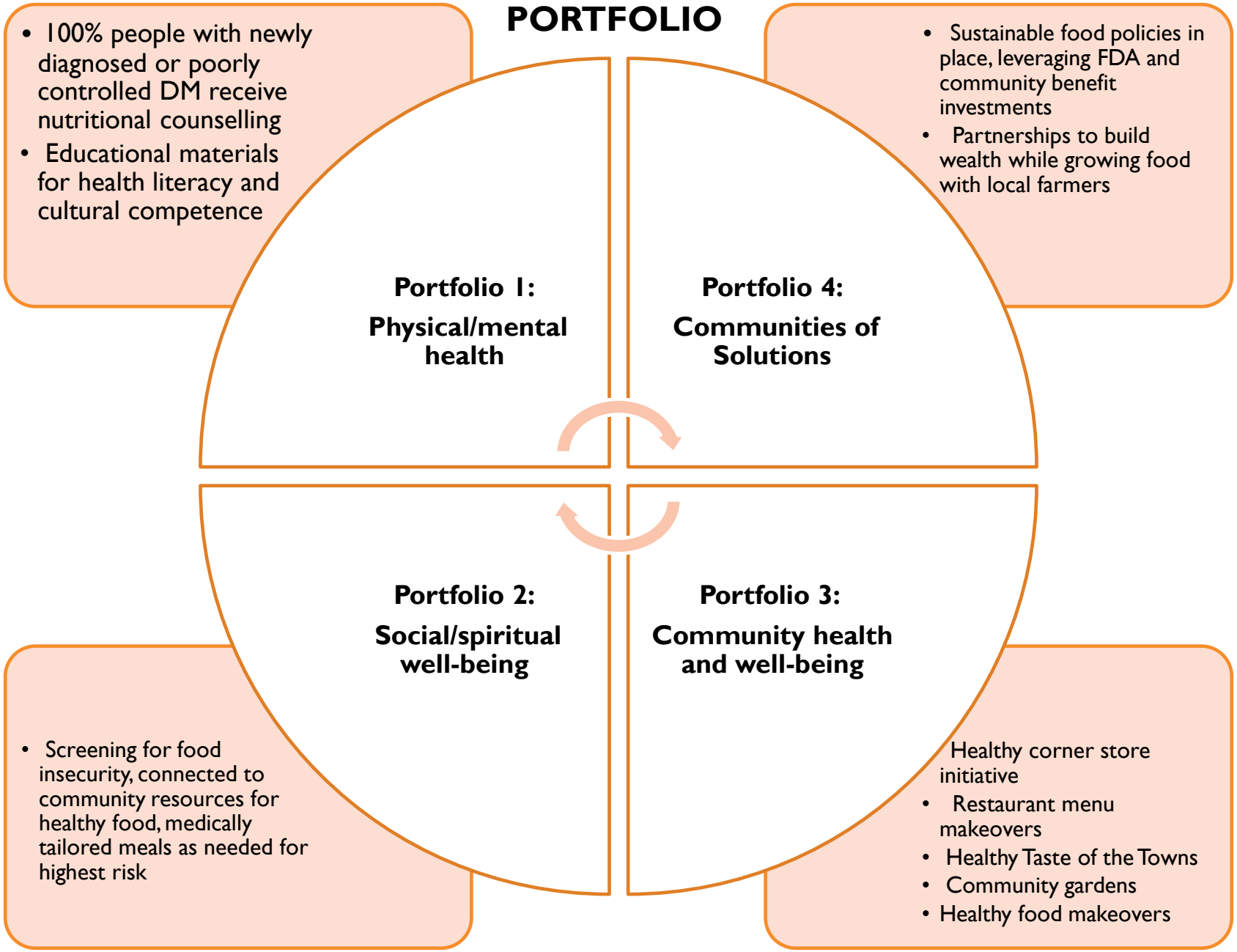
Improving the health and wellbeing of places

Improving the systems that drive (in)equity

Source: Pathways to Population Health, 2018

pathways2pophealth.org

BALANCED PORTFOLIO



Pawtucket/ Central Falls Team Storyboard

June 19, 2020

Agenda

1. Introductions
2. Burden of Diabetes in RI
3. COVID-19 & Health Disparities
4. Overview of Team Assets
5. Discuss Gaps & Working Objectives
6. Next Steps

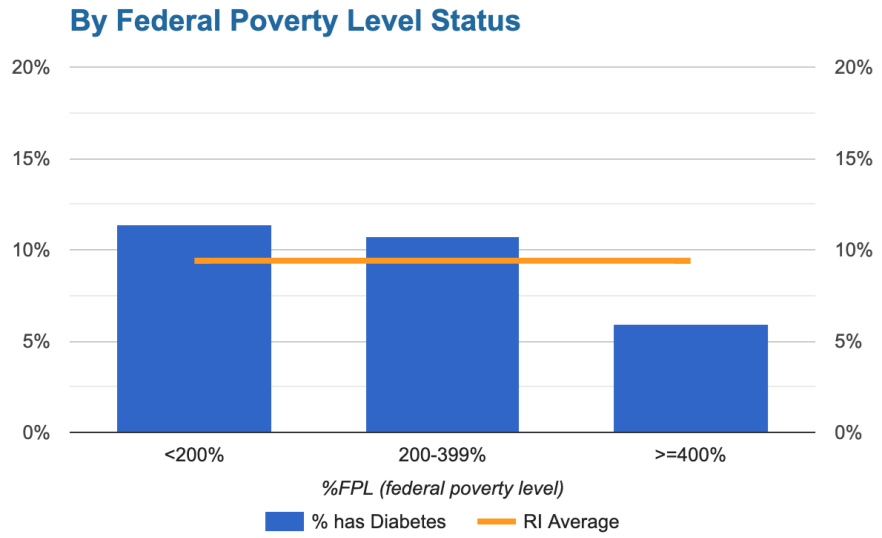
Who are We?

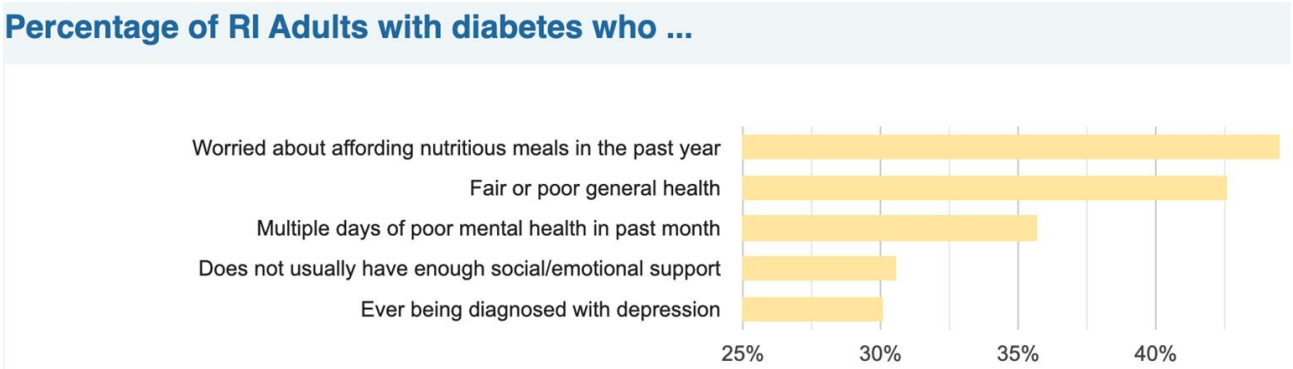
AE:	Integra Community Care Network
CBO:	Progreso Latino
CHT:	Family Service of RI
HEZ:	Pawtucket/Central Falls: LISC
Practice:	CNE MG Internal Medicine Clinic
Person w/lived experience:	Glenit Palacios

Diabetes & COVID-19 in RI

Diabetes in RI

9.4% of RI's adult population know they have diabetes (~80, 000 adults)





Source: RIDOH https://health.ri.gov/data/diabetes/

Diabetes at Integra

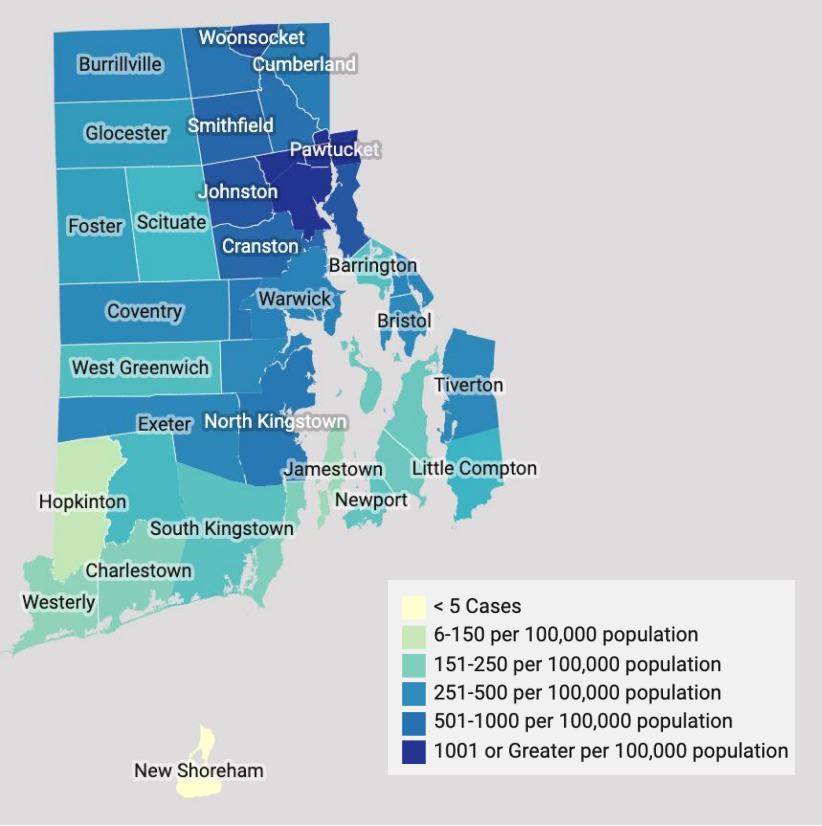
Top 5 Zip Codes

- **02860, Pawtucket**
- 02893, West Warwick
- **02861, Pawtucket**
- 02895, Woonsocket
- **02863, Central Falls**

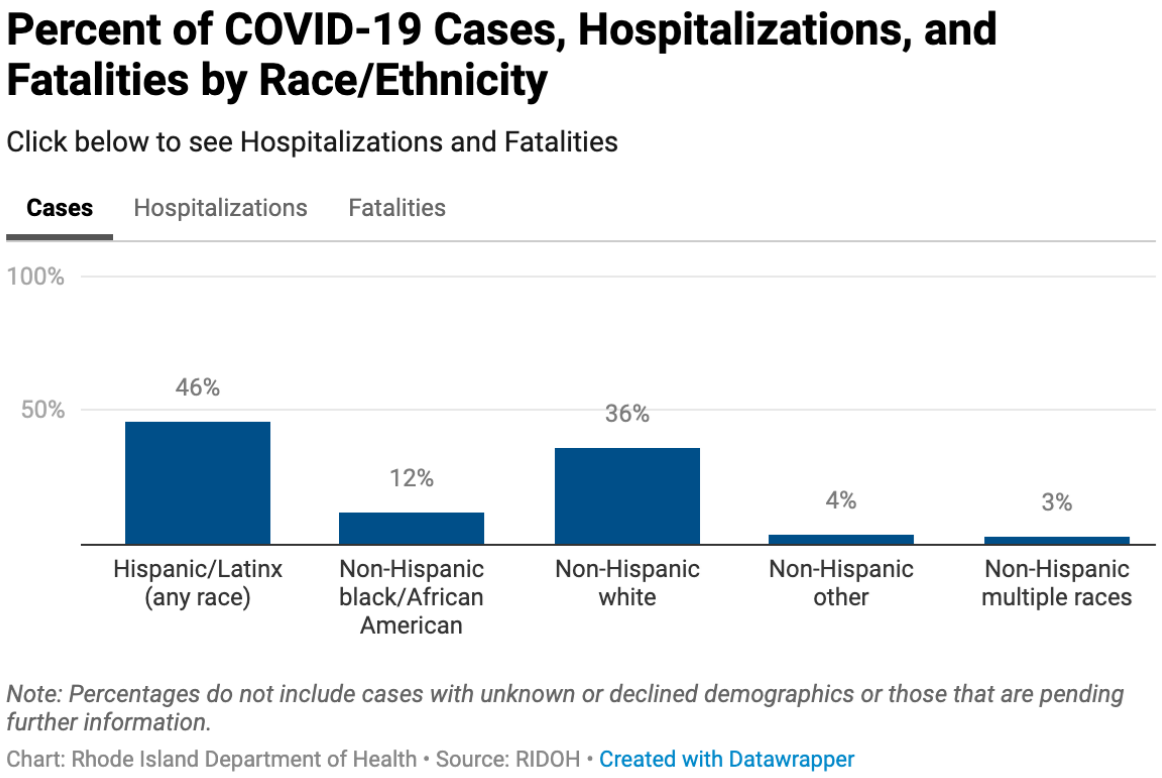
Top 5 Practices

- CNE MG Family Care Center, Pawtucket
- **CNE MG Internal Medicine, Pawtucket**
- CNE MG Family Medicine, Pawtucket
- CNE MG Primary Care, Coventry
- CNE MG Primary Care, East Side

COVID-19 & Health Disparities in RI



Source: RIDOH
Data as of 6/15/20



Our collaborative’s progress on the Health Equity Challenge

Team Assets/ Existing Diabetes Programming

Integra

- Pilot w/Clinica Esperanza to refer members to Vida Sana
- FCC/ Southside Community Land Trust produce program
- Brown medical students' cookbook project

FSRI

- CHW with specialized training in Diabetes Management
- Partnership with PCHC AE
- Healthy food delivery to elderly with special dietary needs
- Free Nutritional Consultation (APRI)

Progreso Latino

- DSME (Diabetes Self Management Education)
- DPP (Diabetes Prevention Program)
  - Both offered in Spanish & English

PCF Health Equity Zone/LISC

- Collaborative Working to Address Health Disparities
- Participant in Path to Wellness Program
- Partner with Healthy Food Access and Food Access Providers

Identified Gaps

1	**Behavioral Health Services/ Case Management**	• People in diabetes programming can't necessarily access behavioral health/ social work services, including team-based services offered by Integra. • FSRI's CHT is newer to this area and to the current teams • Services are often not available in languages people speak
2	**Food Access**	• Progreso has scaled up its food pantry services to respond to surge in needs due to COVID-19 • Emergency food assistance does not normally include healthy options for people living with diabetes
3	**Diabetes Education**	• In-person classes have been canceled • Digital access & literacy are barriers in this community for online diabetes classes

Working Objectives

1. Develop systems by which people engaged in diabetes programs can access appropriate CHT services and supports, and people in CHTs can access diabetes programs.

1. Identify, expand and align specific means by which people living with diabetes can access emergency and supplemental food that is nutritionally appropriate.

1. Identify, align, and build on existing diabetes education programs, and develop effective strategies to overcome or avoid barriers where these programs use technology.

Next Steps

- Interview people with lived experience, to help prioritize gaps and finalize objectives
- Conduct more systematic asset mapping of our organizations
- Situate objectives within Pathways To Population Health framework
- Develop action plans to achieve objectives during project period

EAST PROVIDENCE
HEZ
HEALTH EQUITY ZONE

EBCAP
Story Board

In A Nutshell…

- Our Team
- Person with Lived Experience
- Who We Serve
- HEZ Survey East Providence
- Assets
- Existing Inequities
- Our Goals
- Strategic Plan
- Evidence of Success
- Reflection

Our Team:

- Albert Whitaker, East Providence HEZ Director
- Carla Wahnon, Manager of Integrated Health | CHT
- Caroline Burns, Nurse Care Manager
- Maddy Maher, Nurse Care Manager
- Tammy Joyce

Person with Lived Experience

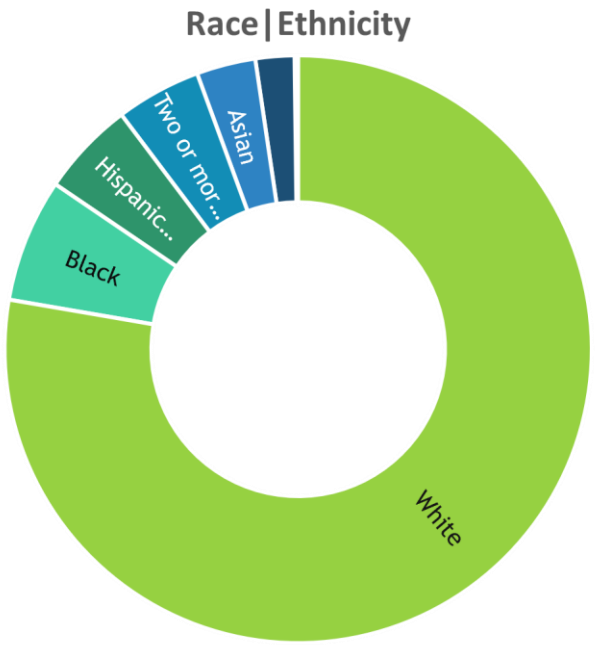
- What has prompted me to help myself and others is the struggle I have seen within my own family. Diabetes has been a part of my life for many years. My mother is insulin dependent and so was my father and grandmother before their passing two years ago. I myself was insulin dependent during my pregnancies and have been on an oral medication for the past 6 months.
- I am a mother of four beautiful children and have been married to my husband for 17 years. I have had gestational diabetes and have been prediabetic since that time. I was diagnosed with diabetes last year

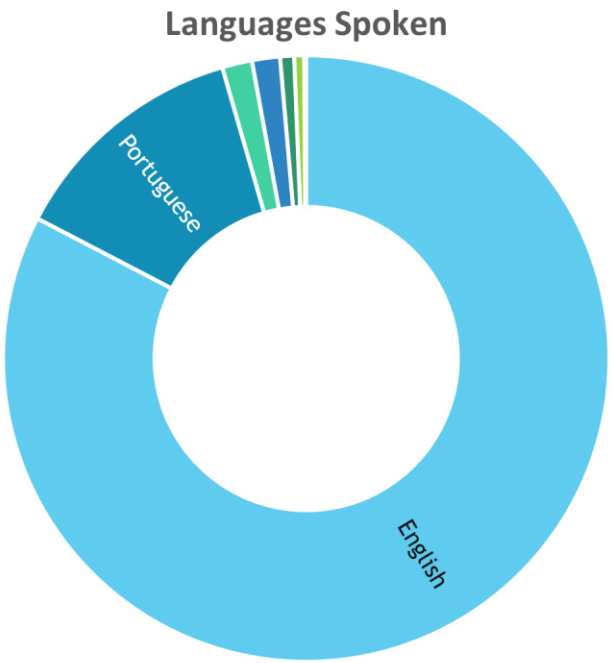
-Tammy

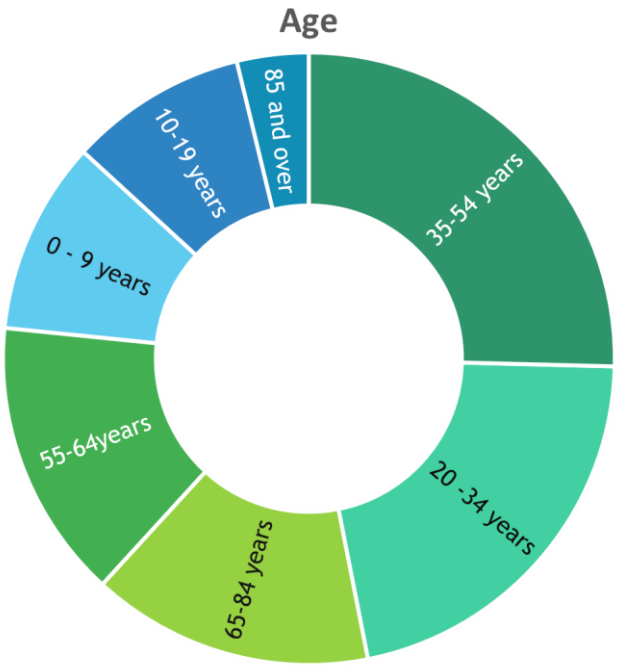
Who We Serve

- East Bay Community Action Program (EBCAP) provides a wide array of health and human services to the residents of Rhode Island's East Bay including the municipalities of East Providence, Barrington, Warren, Bristol, Little Compton, Tiverton, Portsmouth, Middletown, Newport and Jamestown.

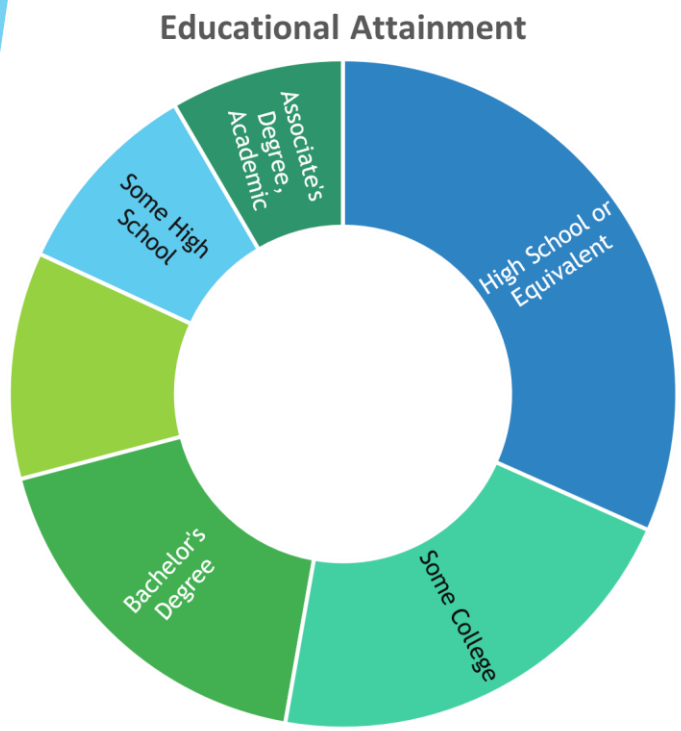
HEZ Survey East Providence

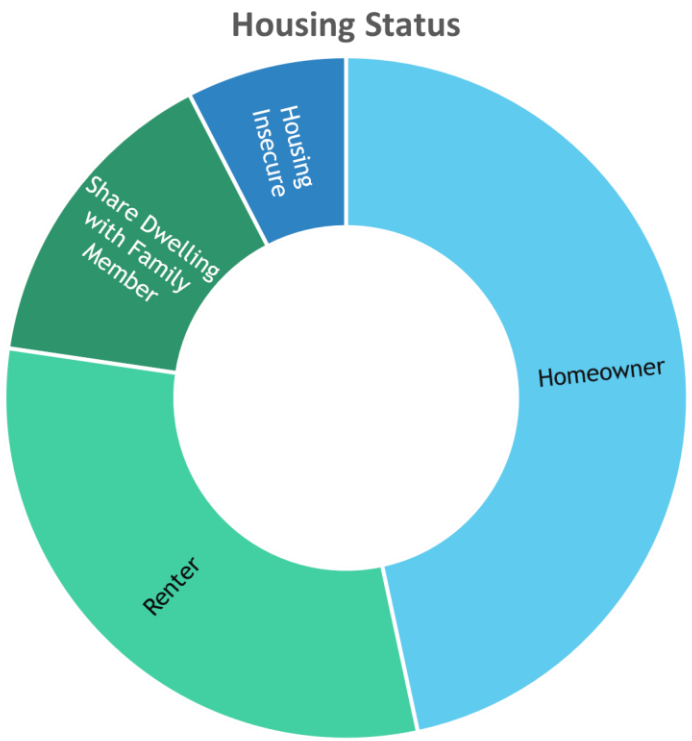


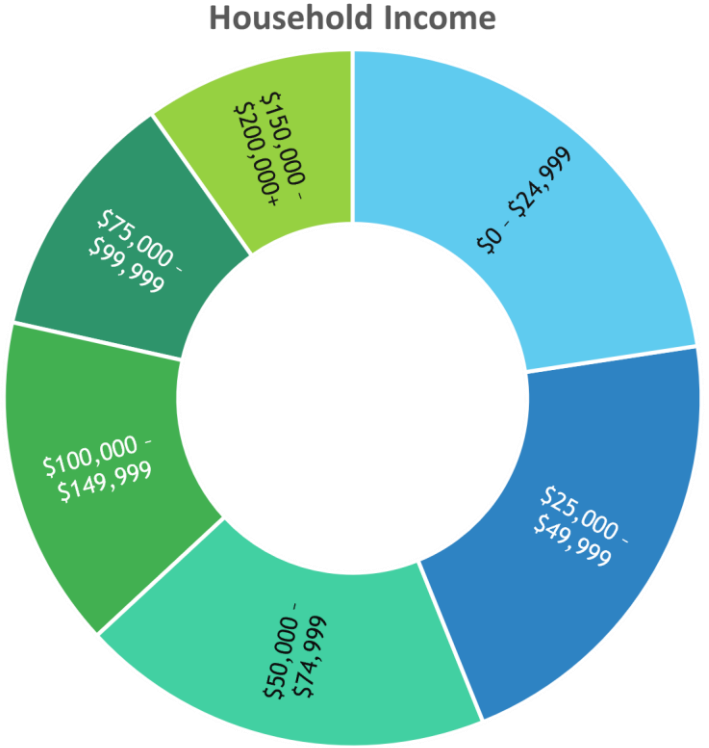




HEZ Survey East Providence



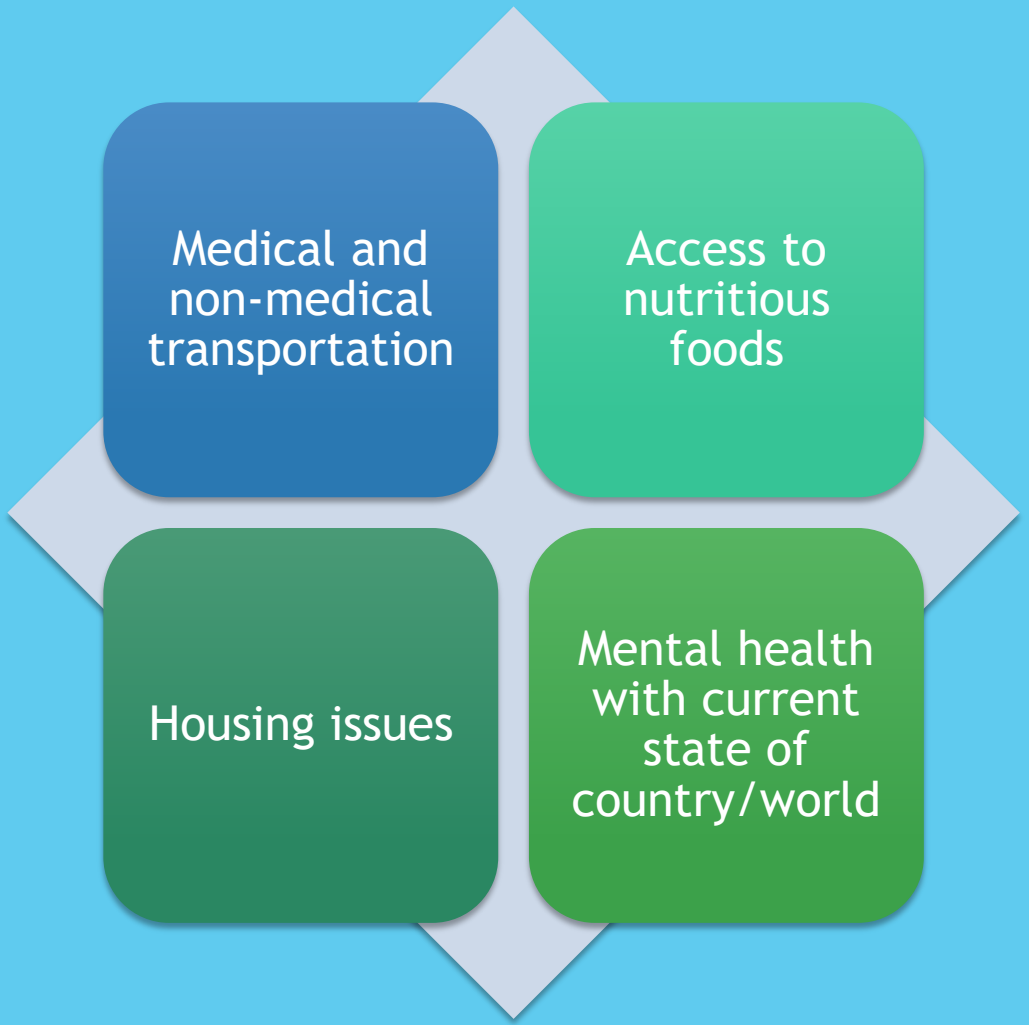




East Bay Assets

- ✓ Telehealth
- ✓ COVID-19 Testing
- ✓ Diabetes Educators
- ✓ Farmers Markets | Farm Fresh RI
- ✓ Mentoring and coaching for seniors
- ✓ AARP support for technology
- ✓ Green spaces in housing developments

Existing Inequities in the East Bay



Our Goals

Community members living with diabetes will have improved access to transportation, nutritious foods, housing, and mental health among other social determinants of health.

Strategic Plan

Develop community partnerships, research, gather data, advocate, and engage

- Transportation: Partner with transportation vendors to provide access to additional medical and non-medical transportation (e.g. to supermarkets, medical referrals, DHS)
- Nutritious foods: Evaluate community food pantries for the ability to introduce fresh fruits and vegetables monthly
- *Housing Issues: Develop Housing Stabilization Programming
- *Mental Health: Address community-wide education around mental health issues and access to services; build on existing community partnerships with behavioral health services and community groups (e.g. emergency responders)

Evidence of Success

- Changes to availability of produce at local pantries
- Increased reports of ease of access to supermarkets, social service sites
- Staff dedicated to housing needs for range of housing situations (unsheltered, couch surfing, unsafe housing situations)
- Increased partnerships dedicated to ensuring access to mental health services

Reflection: What We've Learned So Far

- Everyone experiences living with diabetes differently, starts at a different spot
- Brought to light all of the things that affect people living with diabetes
- We work together effectively as a team
- This was a welcome opportunity to work with staff members across the organization to address a common need, expanding work beyond the individual, being a resource to the community
- The value the person with lived experience brought to this project

Questions?

THANK YOU!

THE NEXT SESSION FOR HEALTH EQUITY CHALLENGE TEAMS WILL BEGIN IN A MOMENT

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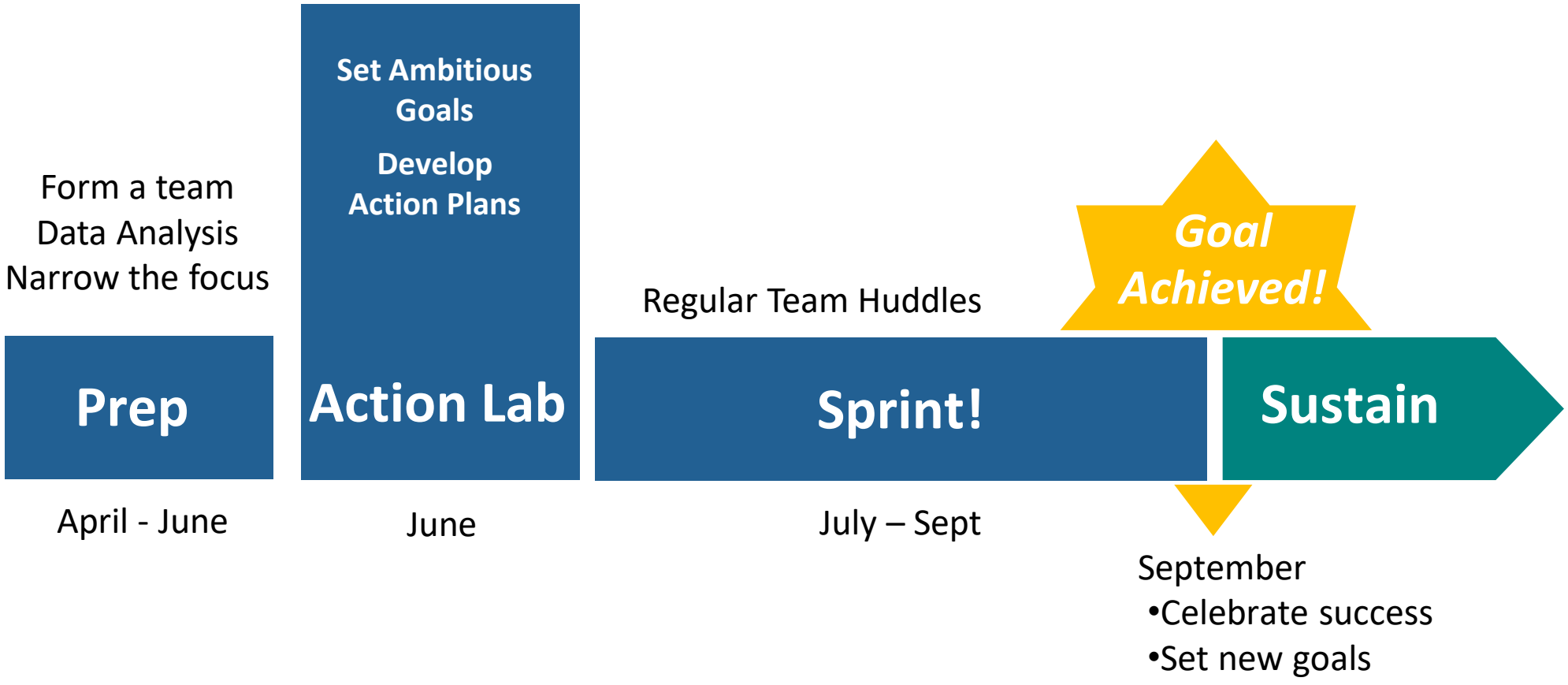
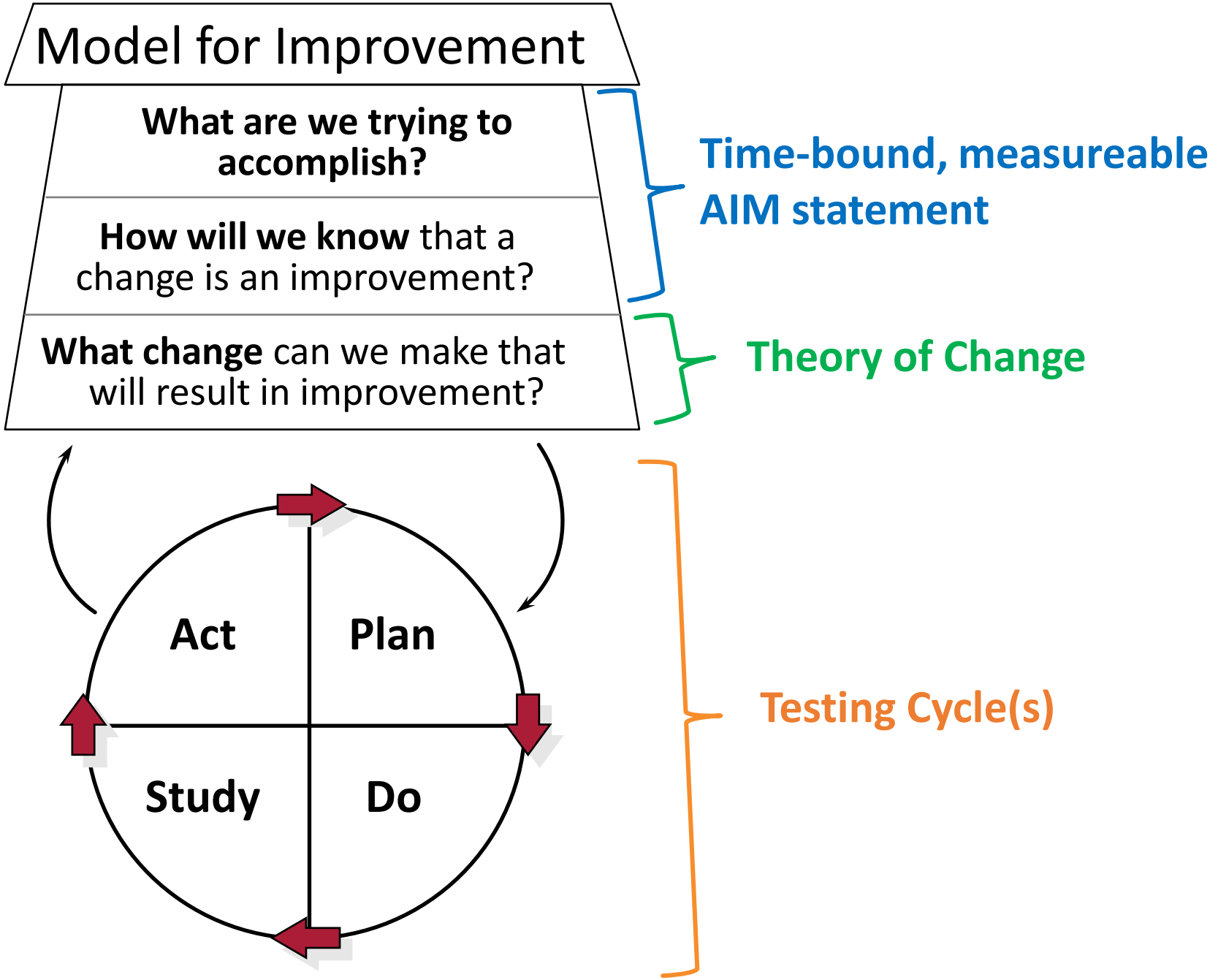
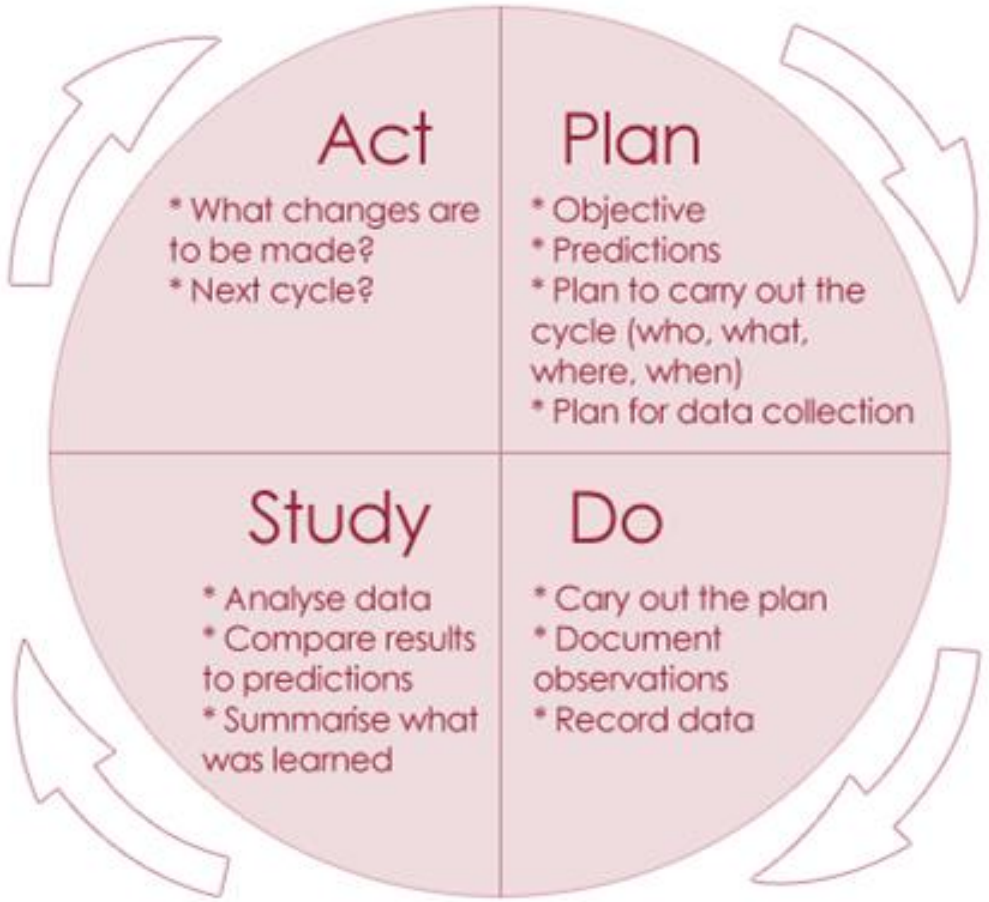
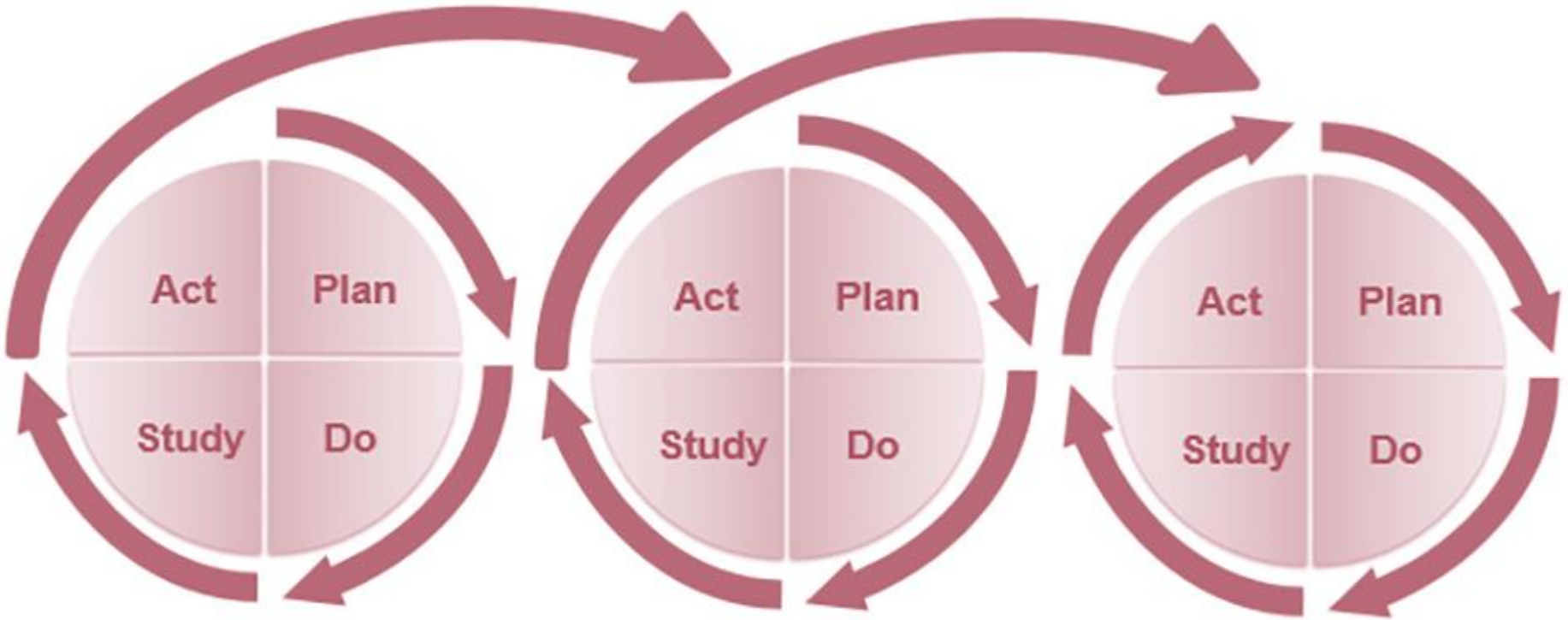



Model for Improvement
What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?
Act
Plan
Study
Do
Time-bound, measureable AIM statement
Theory of Change
Testing Cycle(s)

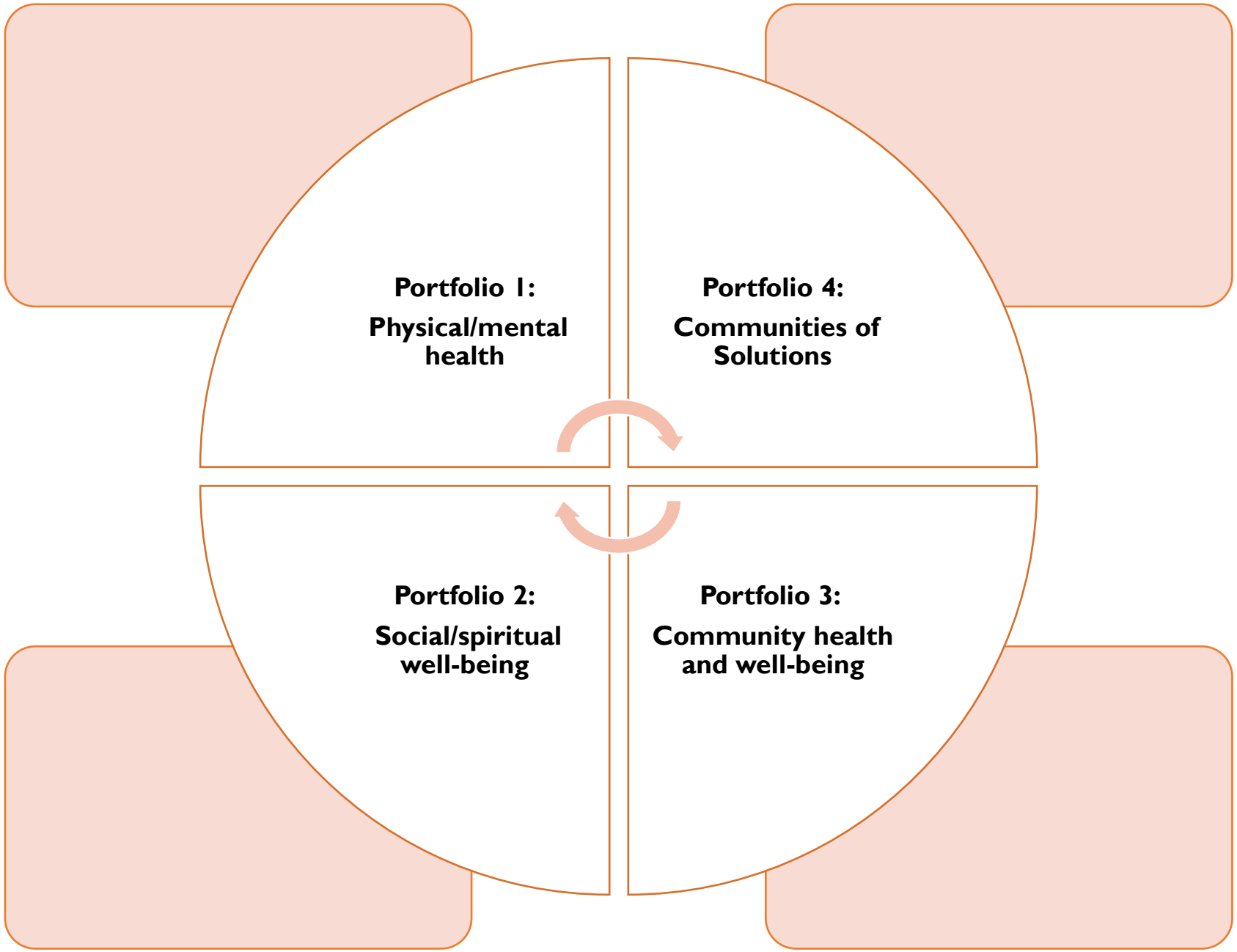
Plan, **D**o, **S**tudy, **A**ct



Rapid Cycle Testing



ALIGNED PORTFOLIO

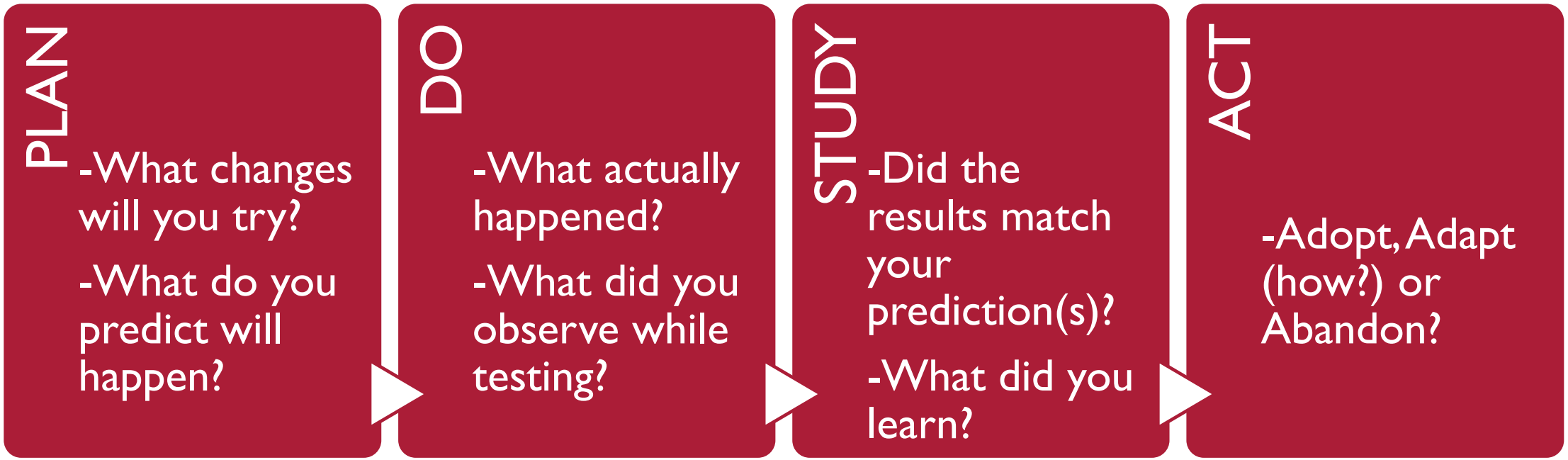


PREPARE FOR ACTION

Breakouts until 1:20 pm

- Pawtucket: Soma / Seth
- EBCAP: Kirsten / Yolanda

Weekly Huddles



THE NEXT STEPS IN THE JOURNEY

Today we…

- Prepared for action using the balanced portfolio,
- Narrowed the focus area
- Considered possible aims

Continue to…

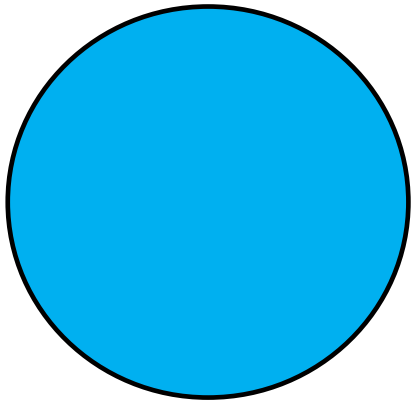
- Develop your action plan for short, medium, and long-term action
- Set a goal for this challenge
- Form a plan for action during this challenge

THE ROAD AHEAD

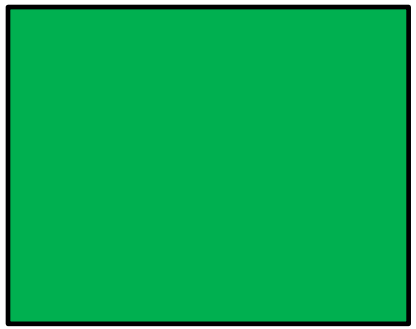
Meetings:

- July 14 – Combined Momentum call
- August 12 - Combined Momentum call
- September 18 – Health Equity Sustainability call
- Weekly Team Huddles

REFLECTION – CIRCLE, TRIANGLE, SQUARE

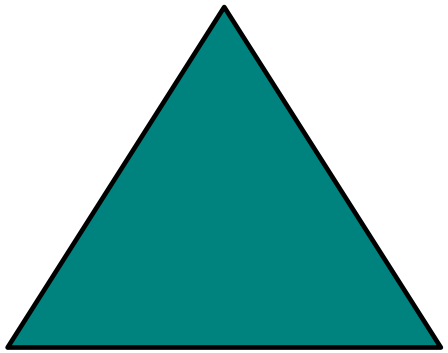


What's still circling around for you?



What do you have squared away

"I've got it"?



What are 3 take-aways that you can put into practice now?

THANK YOU!

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