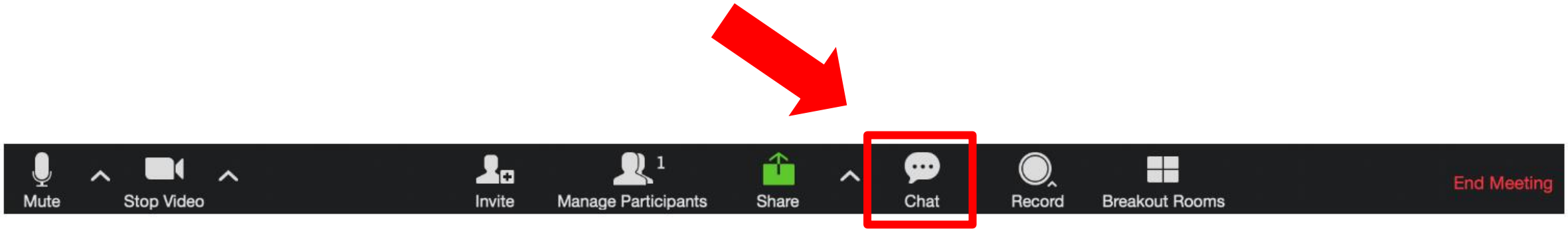
# RI DIABETES HEALTH EQUITY CHALLENGE

Supporting the community during the COVID-19 pandemic

**Welcome! Please feel free to speak or chat in:**

- Name and affiliation
- What's something you're celebrating?

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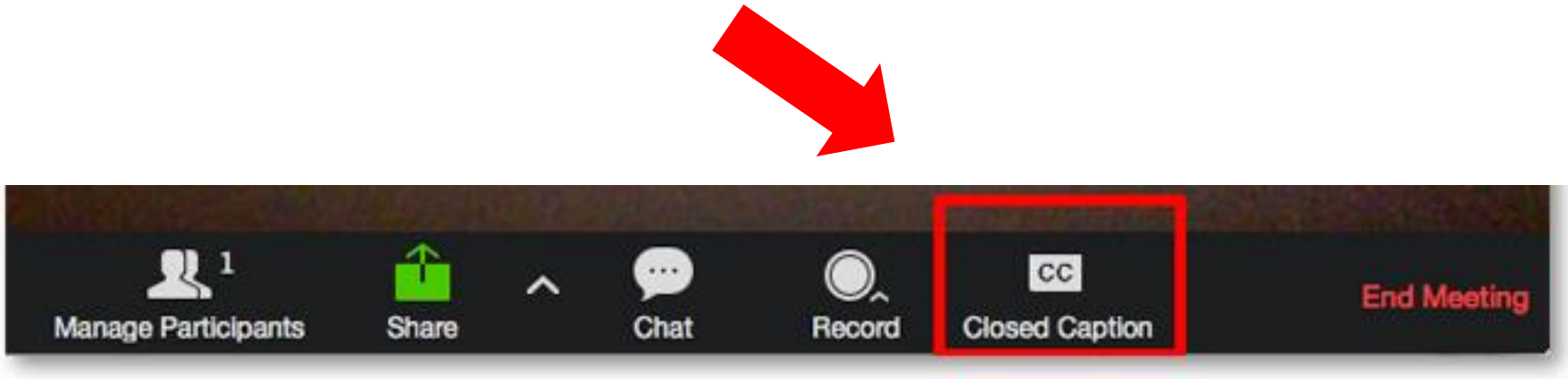
Supporting the community during the COVID-19 pandemic

**Closed captioning is available.**

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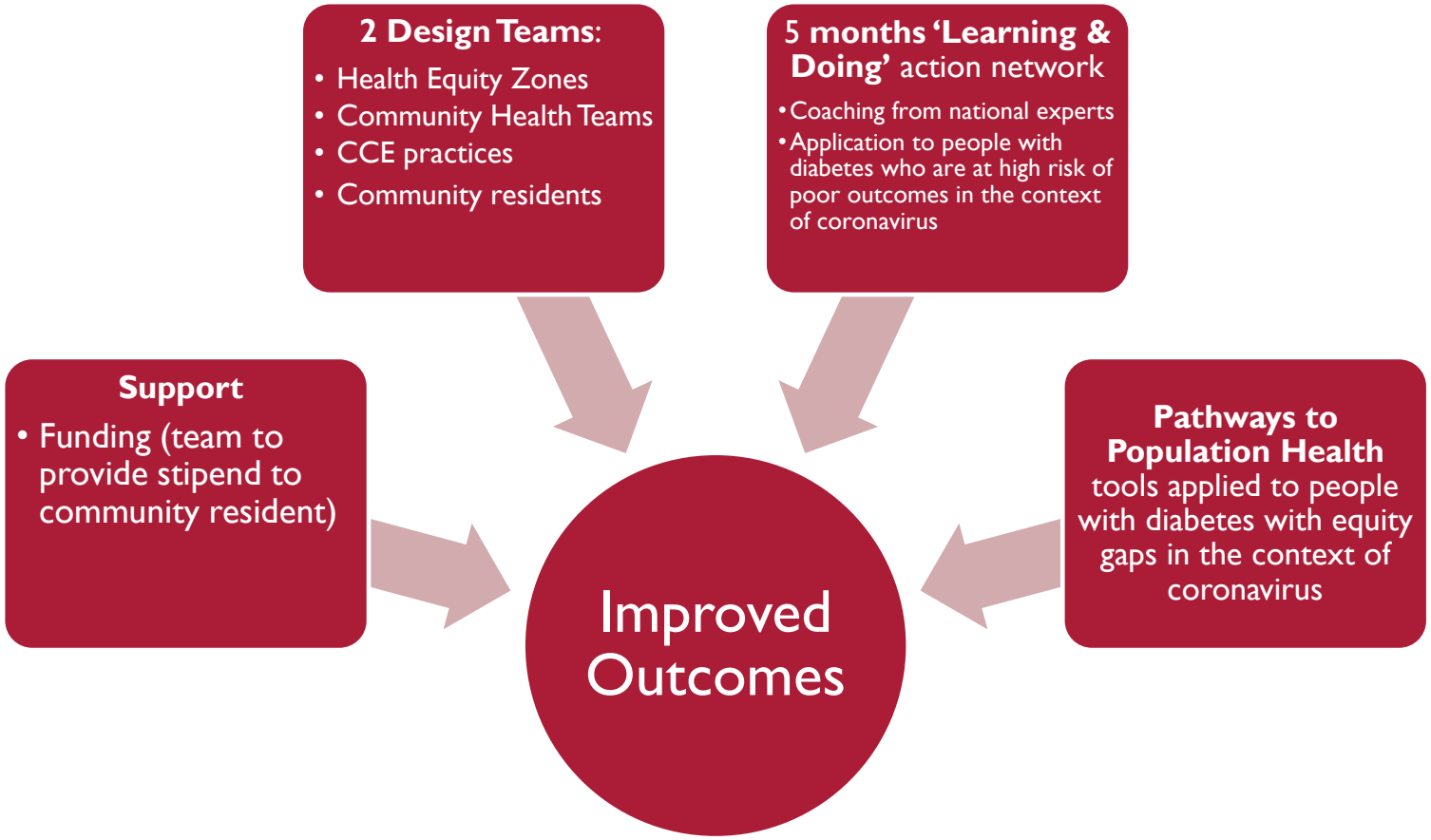
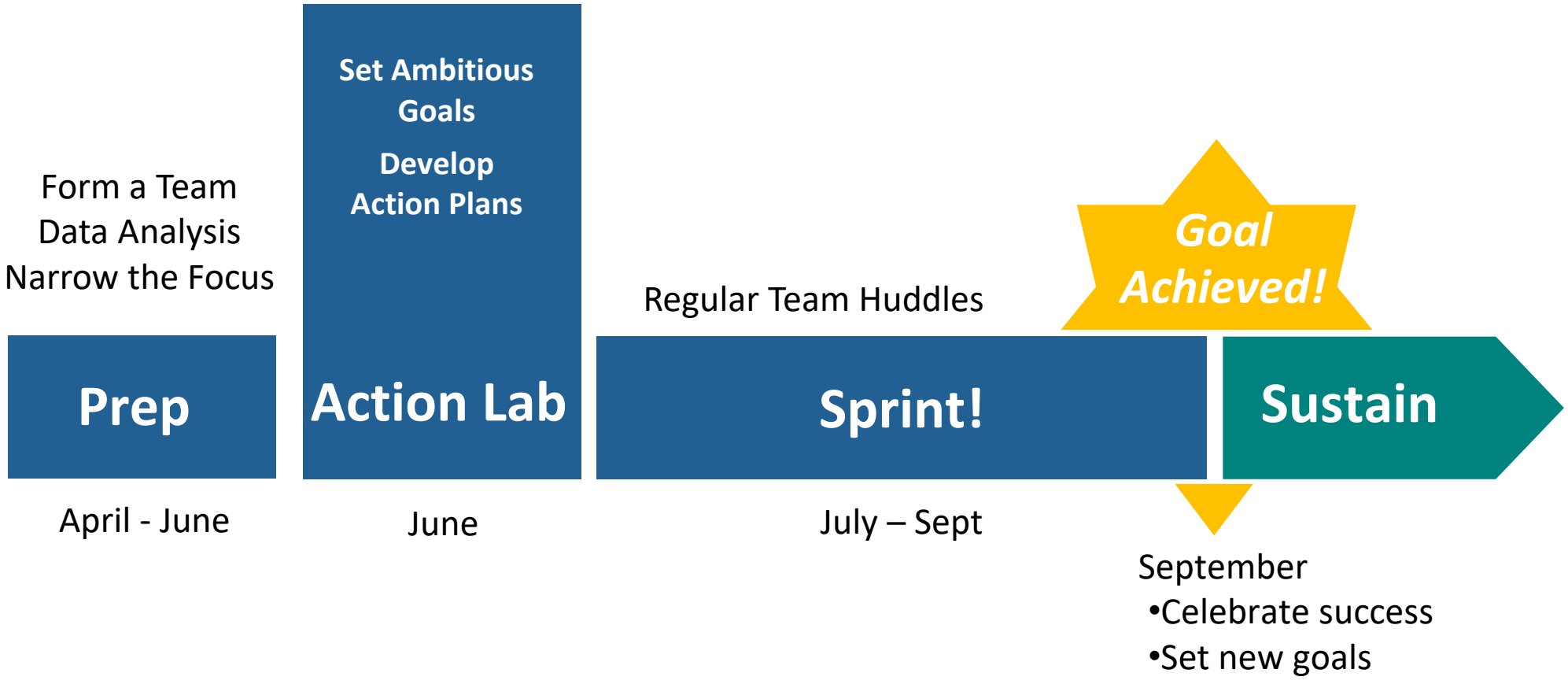


# DIABETES HEALTH EQUITY CHALLENGE



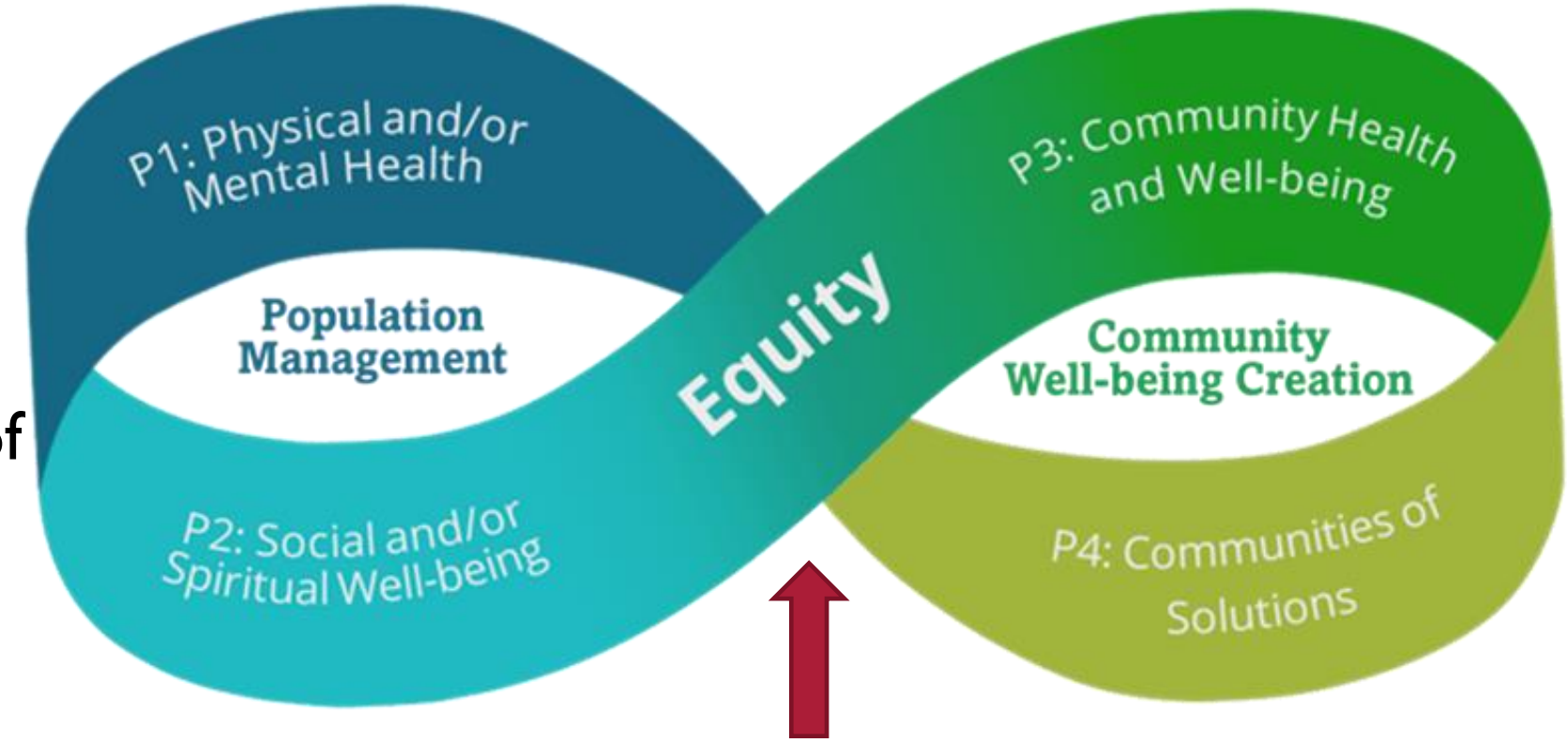
# DIABETES HEALTH EQUITY CHALLENGE

- Learning from people with lived experience of diabetes
- Look at your data (quantitative / stories) Click to add text
- Segment your population
- Identify needs and assets
- Choose a focus area
- Consider a balanced portfolio of work
- Develop your aim statement
- Draft your action plan
- Identify measures to match your action plan
- Develop your tests of change
- Engage additional stakeholders
- Develop an implementation plan

# 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

# TODAY'S AGENDA

| | |
|---|---|
| 9:00-9:45 am | Celebrate learning and progress! |
| | • Teams present their progress and plans for sustainability |
| 9:45-10:30 am | Elements of Sustainability |
| | • P2PH Compass / Balanced Portfolio |
| 10:30-11:00 am | Maintaining the Momentum |
| | • The Rhode to Equity |

# Pawtucket/ Central Falls Team Storyboard

September 18, 2020

# Agenda

1. Introductions & Background
2. Our work as a collaborative
    a. Objective
    b. Identified Gaps
    c. Action Steps
    d. Sustainability

# 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 |

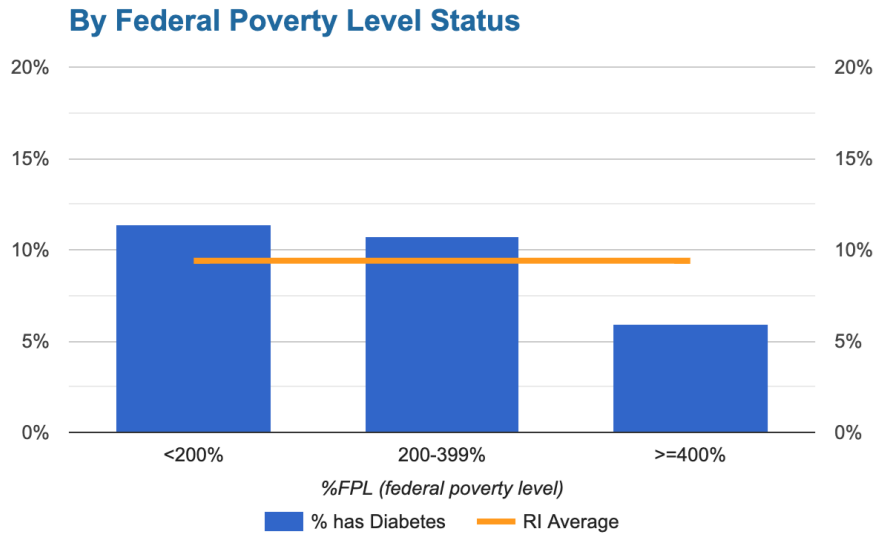


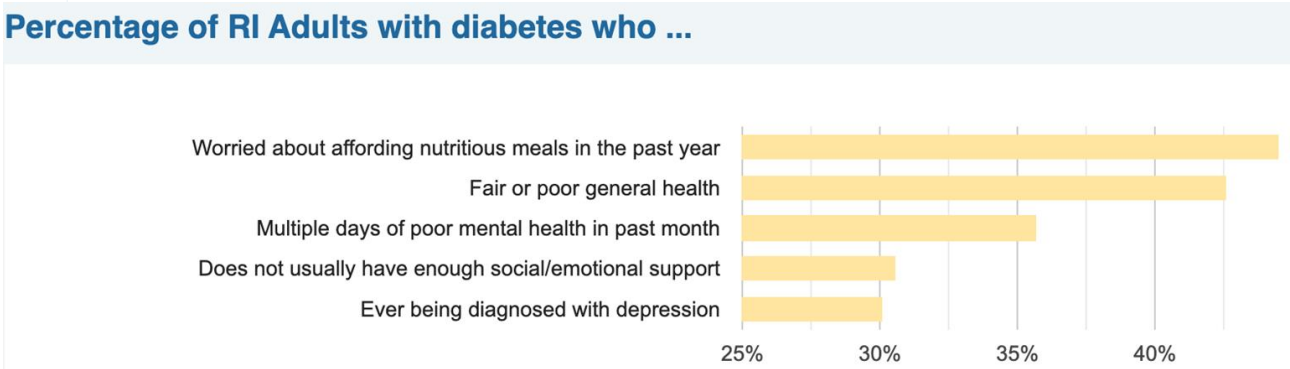



# Diabetes & COVID-19 in RI

# 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

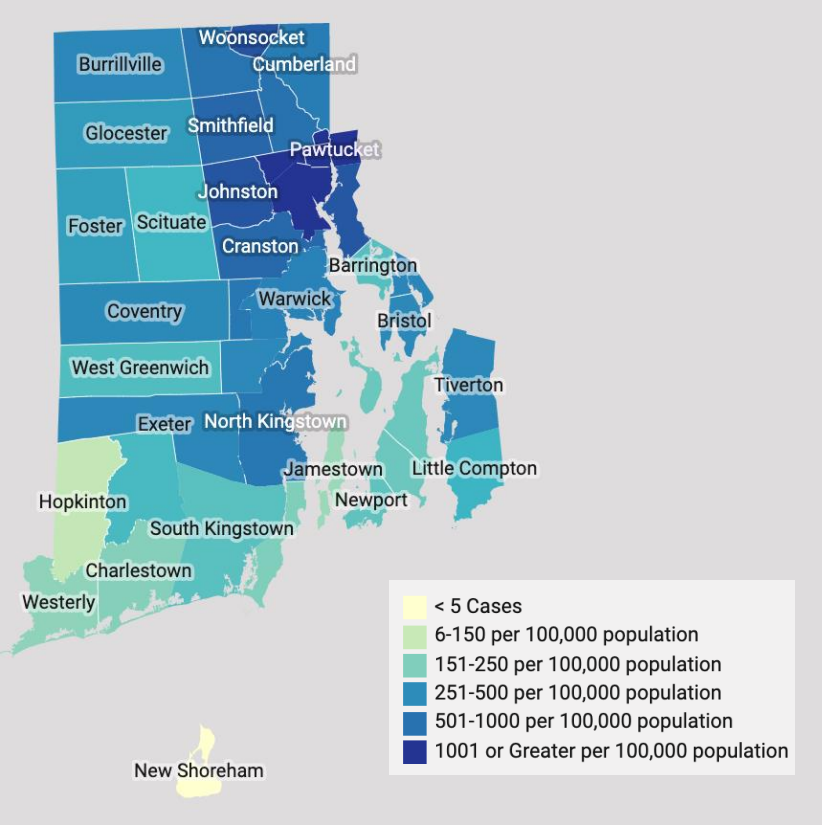
## Top 5 Zip Codes

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

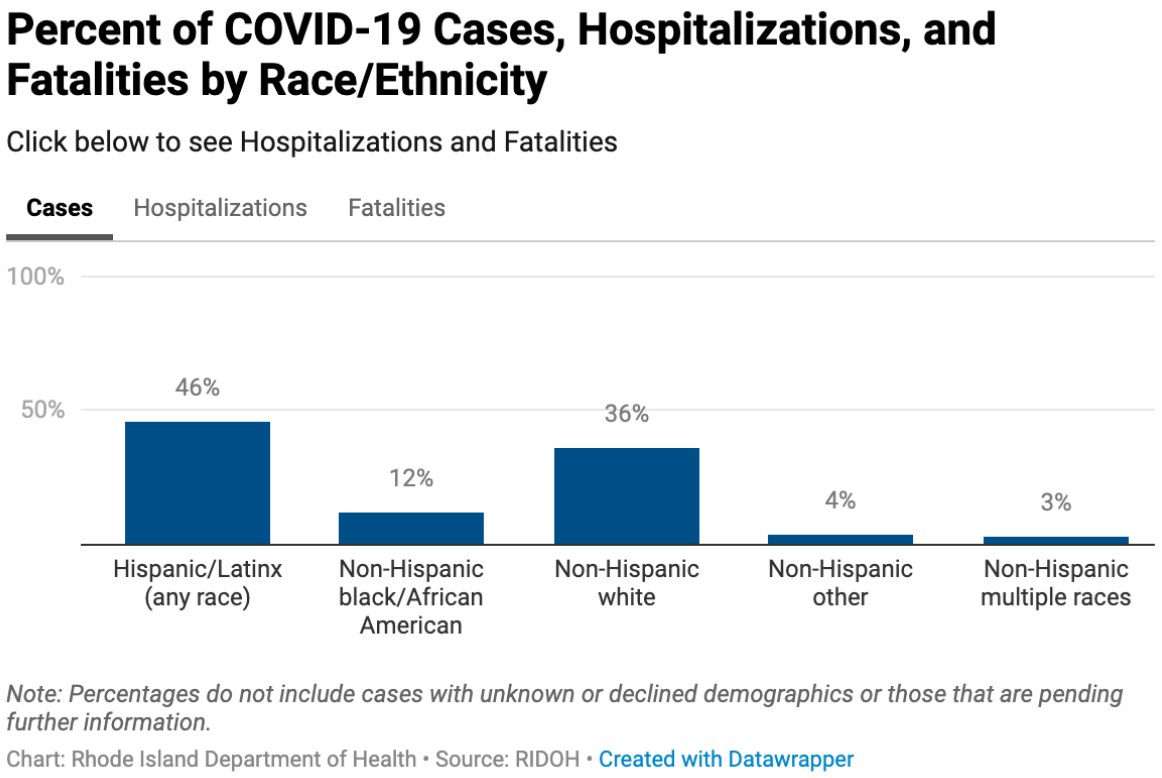
## Top 5 Practices

- 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 work as a Collaborative

# 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.<br>• FSRI's CHT is newer to this area and to the current teams<br>• 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<br>• Emergency food assistance does not normally include healthy options for people living with diabetes |
| 3 | **Diabetes Education** | • In-person classes have been canceled<br>• Digital access & literacy are barriers in this community for online diabetes classes |

# Area of focus

Access to healthy, affordable food was consistently cited as a barrier by all PLE interviewed

2 **Food Access**

- Pogreso 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

Asset mapping showed that food pantries in the area, do not consistently offer foods that are healthy options for PLE

# Objective

By 9/15/2020, inventory existing food and education resources available to people living with diabetes in Pawtucket/Central Falls, understand barriers and facilitators to accessing those resources, implement one distinct collaborative change based on key findings, and propose a plan to sustain it.

# Action

- Deliver healthy food kits (BE SAFE) to a cohort of 15 people living with diabetes  in the Pawtucket/CF area
  - 7 recipients are PLE that were  interviewed throughout the project
  - 8 recipients are IMC patients & Progreso Latino clients
- 2 deliveries will be made to each participant
  - First delivery is scheduled for today!
  - Second delivery will be made sometime in October
- A week after the first delivery, we will contact recipients to get feedback on the kit

# BE SAFE KIT Contents

- Healthy foods that are diabetic friendly
- Masks
- Cleaning supplies
- Measuring cups
- Diabetes placemats

Informed by conversations with PLE

# Follow-up Interview after first delivery

- Did the kit have the kind of food you like to eat? Y/N
  - What did you like? [short answer]
- Were you able to use all the food? Y/N
  - Anything you didn't use? Y/N [short answer]
- Did this food help you eat in a way that helps you manage your diabetes? Y/N
- Anything we can improve for next time? Y/N [short answer]
- Would you like another kit? Y/N

**CCM/CHT interest question**

I work with a team of community health workers, and social workers who help people solve problems related to their health conditions. For example, if you're having trouble with your housing situation, paying the bills, putting food on the table, and managing your diabetes, they may be able to offer some resources. Would you be interested in talking to somebody about getting some extra help with your health?

# Thinking about Sustainability

Explore opportunity with Rhode Island Community Food Bank

1. Pawtucket/CF team & EBCAP team approach Food Bank to understand current practices
2. Determine whether Food Bank has the capacity to tailor food assistance boxes
3. Work  with FSRI and Progreso Latino to understand costs associated with sustaining and expanding tailored BE SAFE kits.

Other suggestions/ recommendations?

# Thank you!

Community Health Team

EAST PROVIDENCE HEZ HEALTH EQUITY ZONE

# EBCAP Team Story Board

# Our Presentation in a Nutshell…

What Is EBCAP

Our Team

Interviews of People with Lived Experience

Who We Serve

HEZ Survey East Providence

Existing Inequities

Aligned Portfolio

Our Aim and Vision

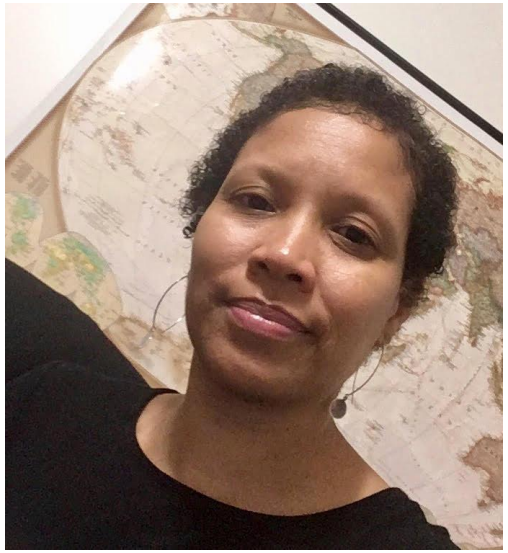
Strategic Plan

Evidence of Success & Progress

Reflections

# What is EBCAP?

At EBCAP we believe in justice, equality, humanity, and dignity. We believe that people have the right to exceptional, affordable health care. We care deeply about the whole person, so we provide other services besides healthcare, and referrals to other programs that may provide what we don't. We respect and value our clients, our patients, our staff, and our community. We want to help people flourish, so we work hard to provide opportunities for growth, and we do this with compassion, empathy, and determination. We support, we value, we believe in the very best in people, and we will never give up on treating people with fairness and decency. We are EBCAP.

# Our DHEC Team:

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

# Person with Lived Experience: Tammy

"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

# Person with Lived Experience: Jamie

I learned about 20 years ago that I was diabetic quite by accident and it took another 15 years to learn I became diabetic due to a medication. Since then I've faced a new way of having to live, but only recently a newer way still of what foods I can and cannot put into my body. Recently I became insulin dependent and if I had been educated about the dangers of foods perhaps I wouldn't be on insulin today. My belief is that many people including those who will never become diabetic could benefit from, food education. I've had to learn in a short time...weeks, all the foods that aren't good for me and/or how to reduce in portion size many of the foods we take for granted eating. I've had to learn how to measure my foods, what size portions I'm allowed at each meal and what fruits and vegetables I should and shouldn't eat this is to say the least in what we as diabetics have to learn and the process takes more time than a matter of weeks. I am not an expert on my foods, portion sizes and the labels we must figure out before and during shopping. These are just a few of the challenges. There are so many more. Such as my health. In the past couple of years my eye site has worsened, the arthritis I have had for years has become more so and more painful and the worry of my liver, kidneys, lungs and heart becomes a daily concern all based on the foods I put in my body. I ask myself every time I sit for a meal, "is this food okay and if it is, am I eating to much, did I measure correctly and am I eating to many carbs at this meal?"

I also find myself praying that when I test before breakfast that I did everything correctly the day before so that my numbers are between 60 and 120 and if they aren't I must figure out what I did wrong the day before so that hopefully I won't be a repeat offender.
The challenge of getting the daily fresh vegetables for salad making is quite difficult in that the expense becomes enormous when combined with all the other foods I must put on my plate three times a day. And then there's trying to find a way to access the grocers. If you don't have transportation getting what you need on a weekly basis becomes another worry. I am not always able to get to the market and when I am it isn't easy lugging bags onto the public transportation. If I'm not worrying how diabetes is affecting my health, I'm worrying if I measured all my meals correctly and if I'm eating the right foods. I think my biggest challenge has been being able to afford the right foods and having transportation. I have accessed the local food bank and God bless them for their willingness to help, but honestly, the foods they distribute do not help me in that none of what is handed out is good for feeding this demon...diabetes!

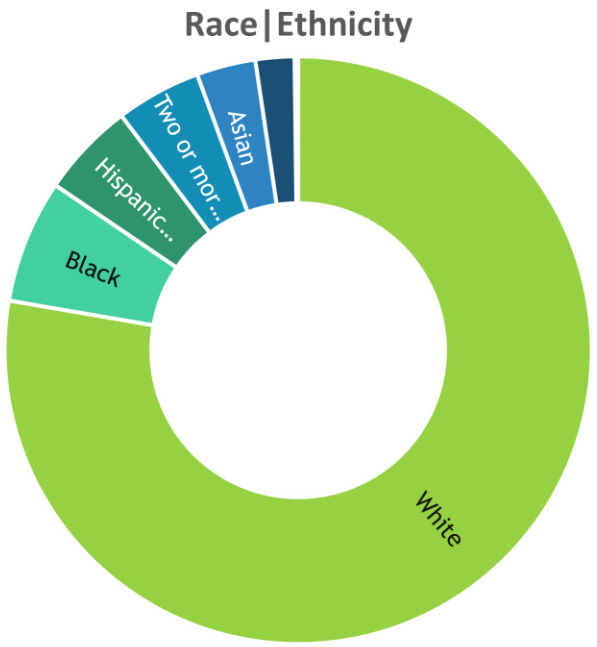
As an insulin dependent  diabetic I don't know if I'll be able to do all the right things to care for my disease, but hopefully and with the help of God, and working with the caring community health team, perhaps one day I as well as others won't have to have so many worries and that we'll be able to wake everyday healthier than the day before and have fewer challenges and fewer affects.

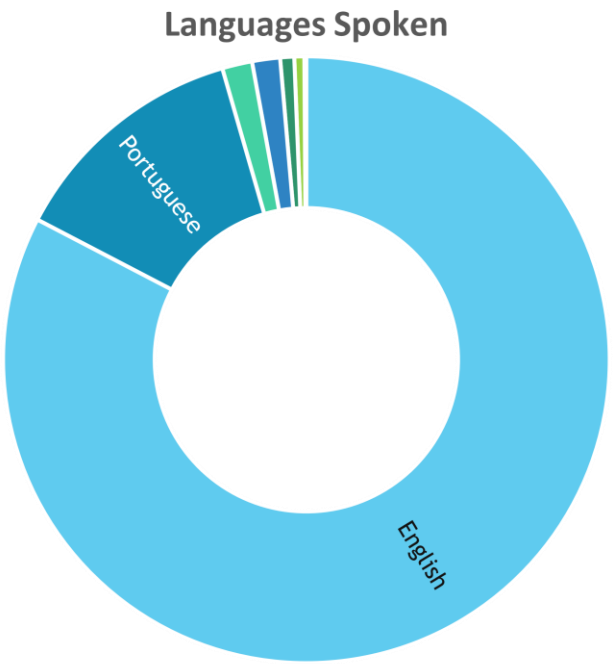
-Jamie

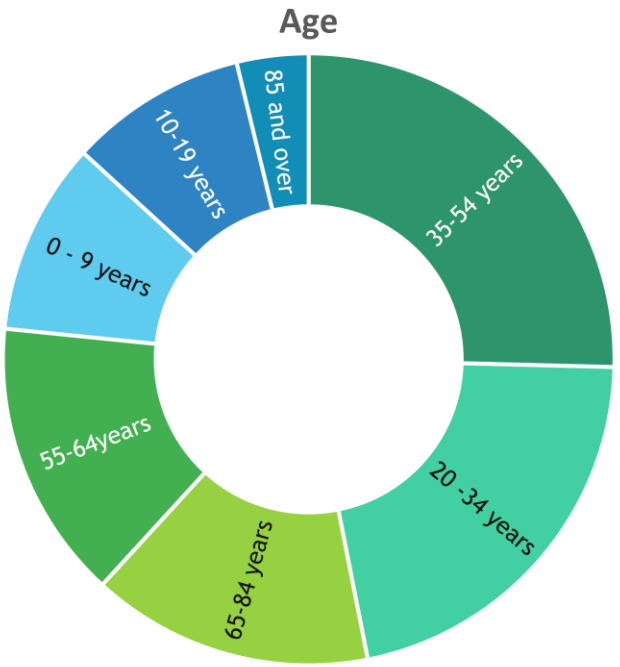
# Who We Serve

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



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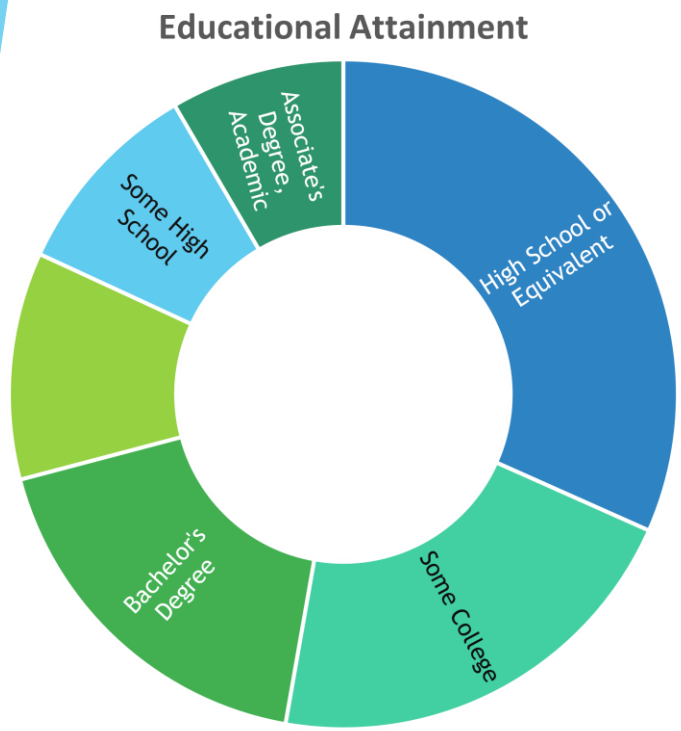
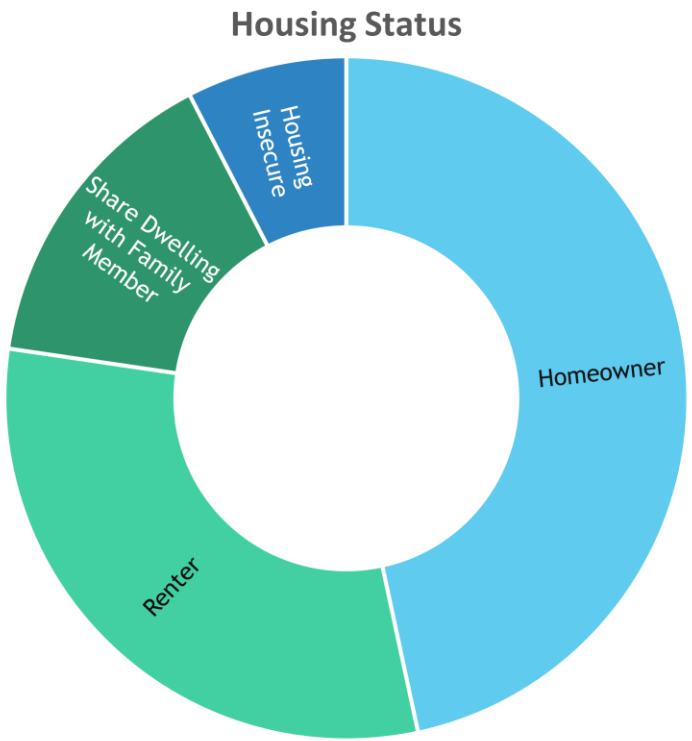
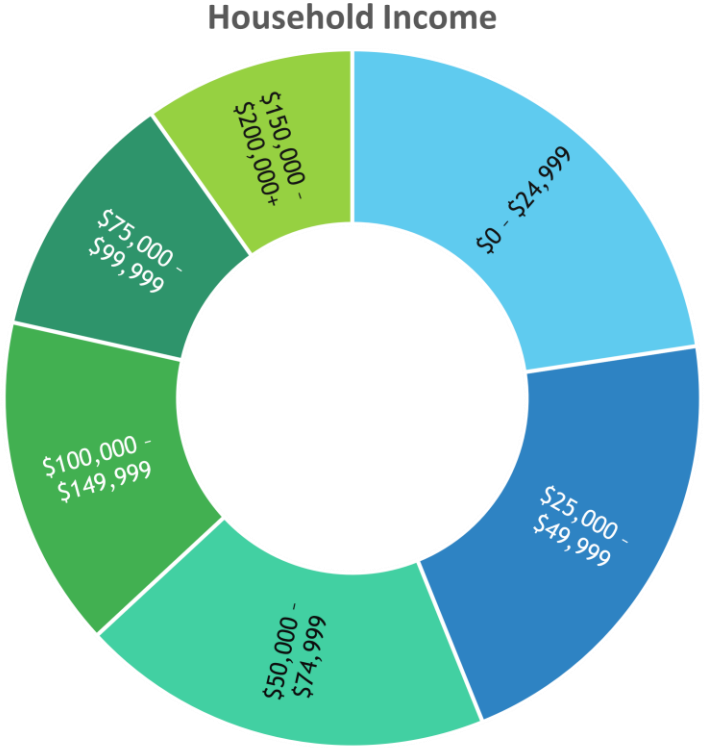
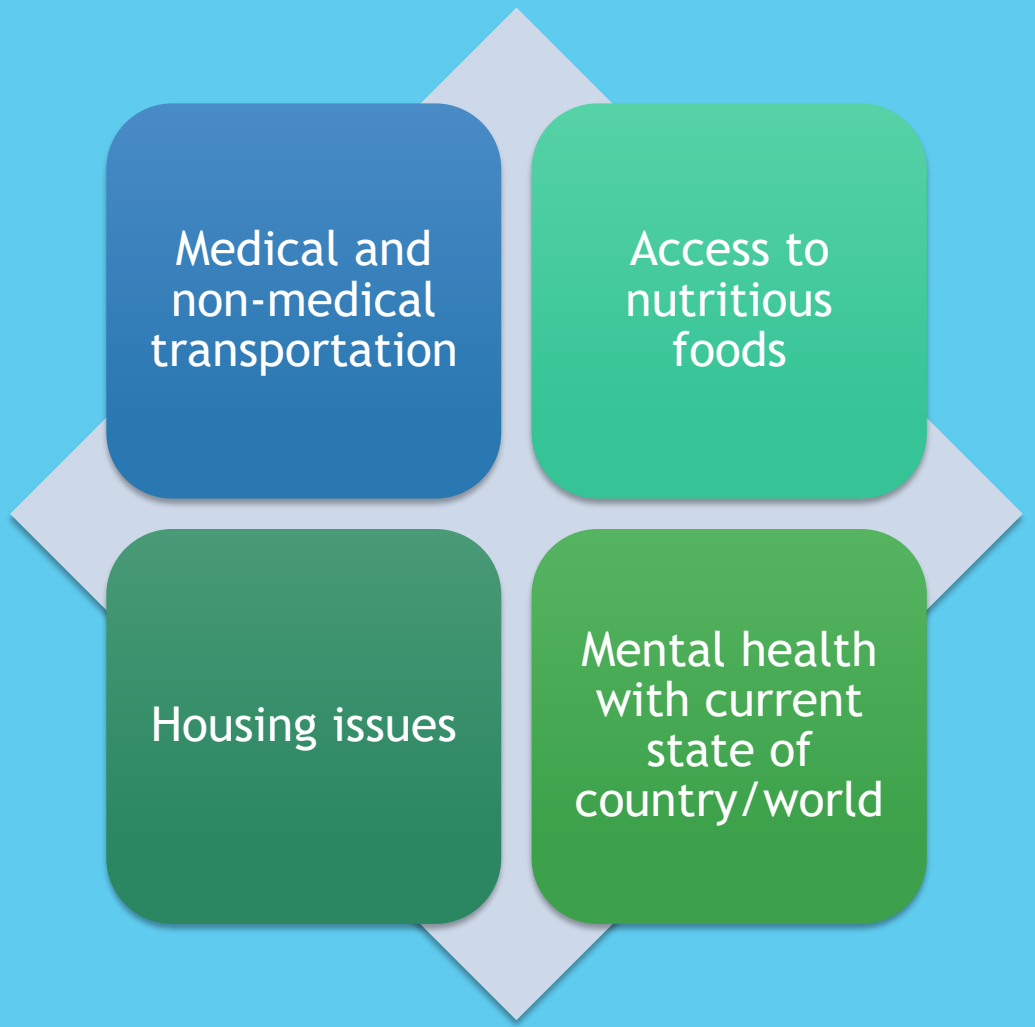


# Existing Inequities in the East Bay



# Our Aim and Vision

By September 2020, ten people living with diabetes who utilize the EBCAP food pantry will have increased access to fresh fruits and vegetables as a first step toward a healthier diet and a sustainable community solution.

# Strategic Plan

## Step One: Information Gathering

- Discussing current methods with EBCAP food pantry director/staff
- Calling existing food pantries in the area to see what they do to increase fresh fruit and vegetable access to their patrons
- Researching online for possible solutions from around the country/world
- Discussing fresh fruit and vegetable access with patients we interact with daily

## Step Two: Intervention Implementation

- Develop intervention strategy and implement in iterative conversations with patients living with diabetes.
- Strategy – recruitment from OCR, community members currently using food pantry, CHT patients, general patient population
- Outreach to Exeter farms, Family Service RI. (produce delivered – work on logistics)

## Step Three: Evaluation

- Gather post-intervention data
- Generate report to evaluate effectiveness of intervention

# Evidence for Success & Progress

**Success!** Five people received bags of diabetic diet-friendly foods.

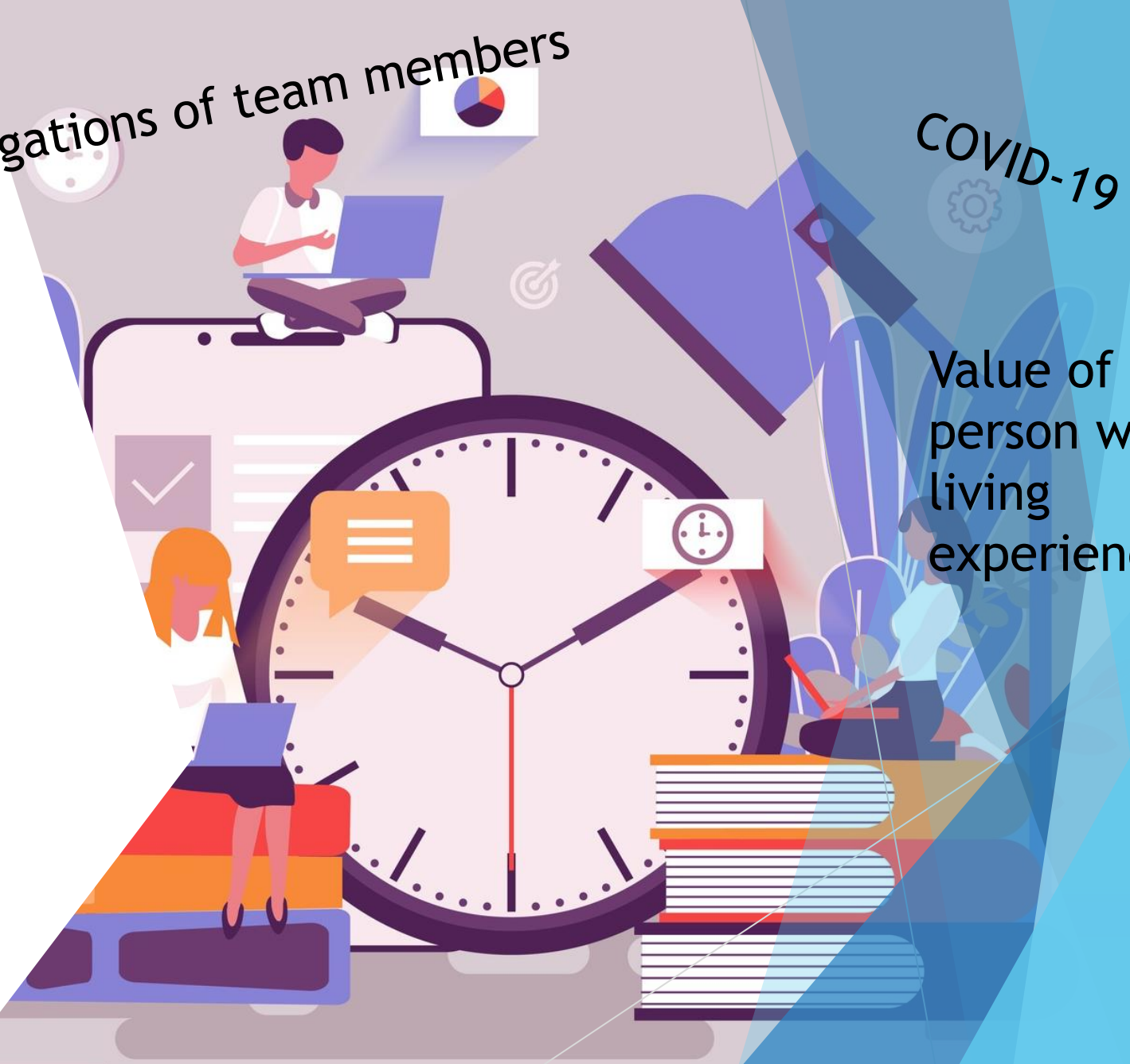
Initial surveys done on each participant- comparative surveys to be completed in a couple weeks.

# Reflection & Barriers

Time and conflicting obligations of team members

COVID-19

Value of a person with living experience



Everyone has different experiences to bring to the table

Identifying patients who fall into our specific category

# Looking to the Future: Sustainability

How do we make this sustainable?
Where do we go past September?

# Questions?

# LEADING FOR SUSTAINABILITY

- What would it look like to go full scale?
- Consider the elements of Sustainability
- A Balanced Portfolio can support sustained change
- P2PH Compass is a tool to measure progress and map a path forward

# THE CHOLUTECA BRIDGE, HONDURAS

Munster, B. "Why A Honduran Bridge Is A Perfect Metaphor For Disruption"

https://medium.com/road-less-ventured/why-an-honduran-bridge-is-a-perfect-metaphor-for-disruption-2a2d7c910535

- Static sustainability – Maintaining systems, programs, policies, and practices as they are

Choluteca Bridge, Honduras

https://twitter.com/docreggies/status/947991960278781954

# GENERATIVE SUSTAINABILITY

- Dynamic
- Sustains the change process
- Allows for adaptation based on changing conditions
- Allows programs, systems, policies and practices that are no longer relevant to be phased out and new programs to take their place
- Invites planning for scaling of programs, systems, policies and practices that are relevant

# 4 DOMAINS OF PLANNING FOR GENERATIVE SUSTAINABILITY

# LEADING FOR SUSTAINABILITY

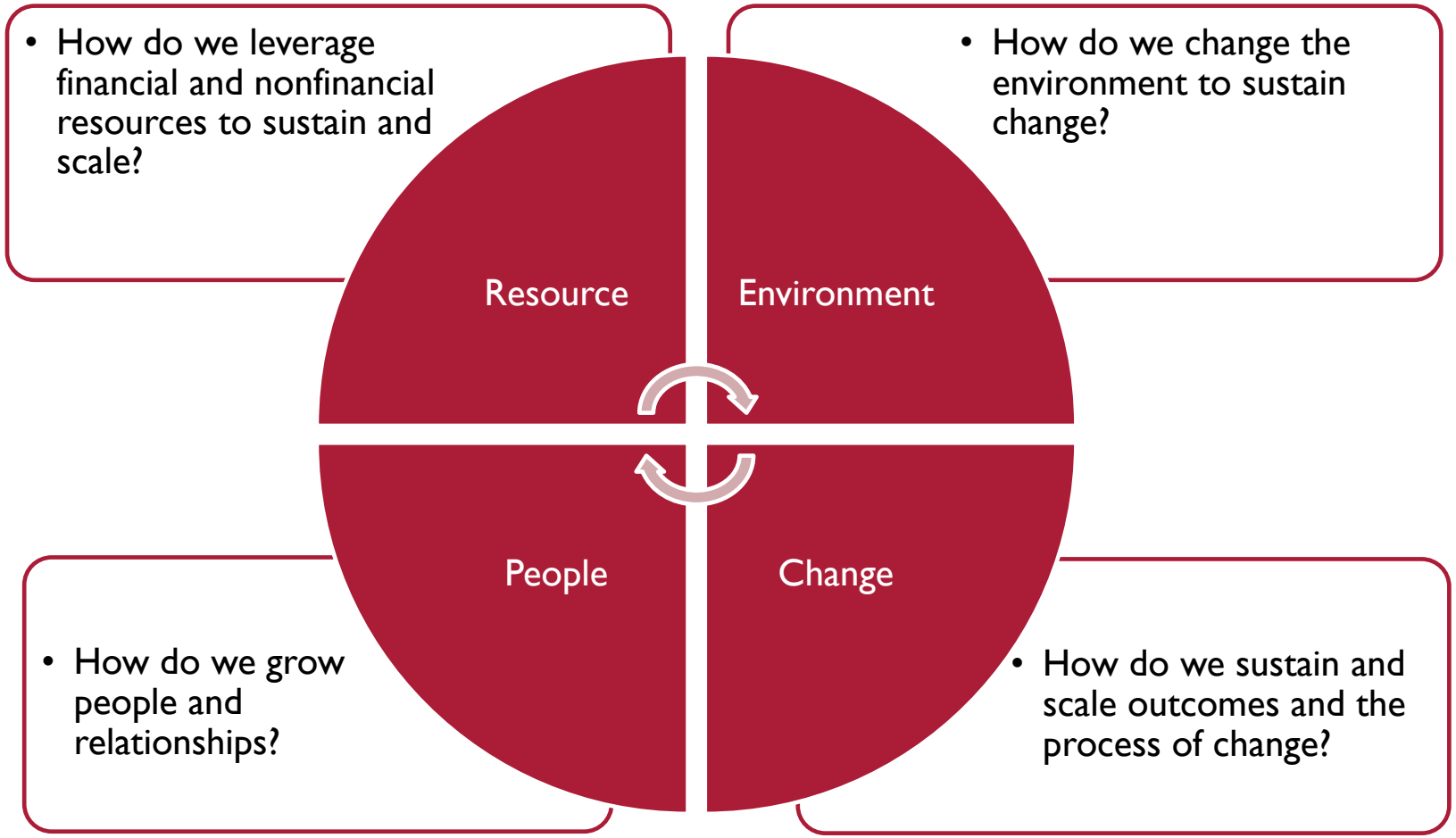



Photo courtesy of Kaique Rocha.  Metaphor courtesy of Camara Jones and Natalie Burke.

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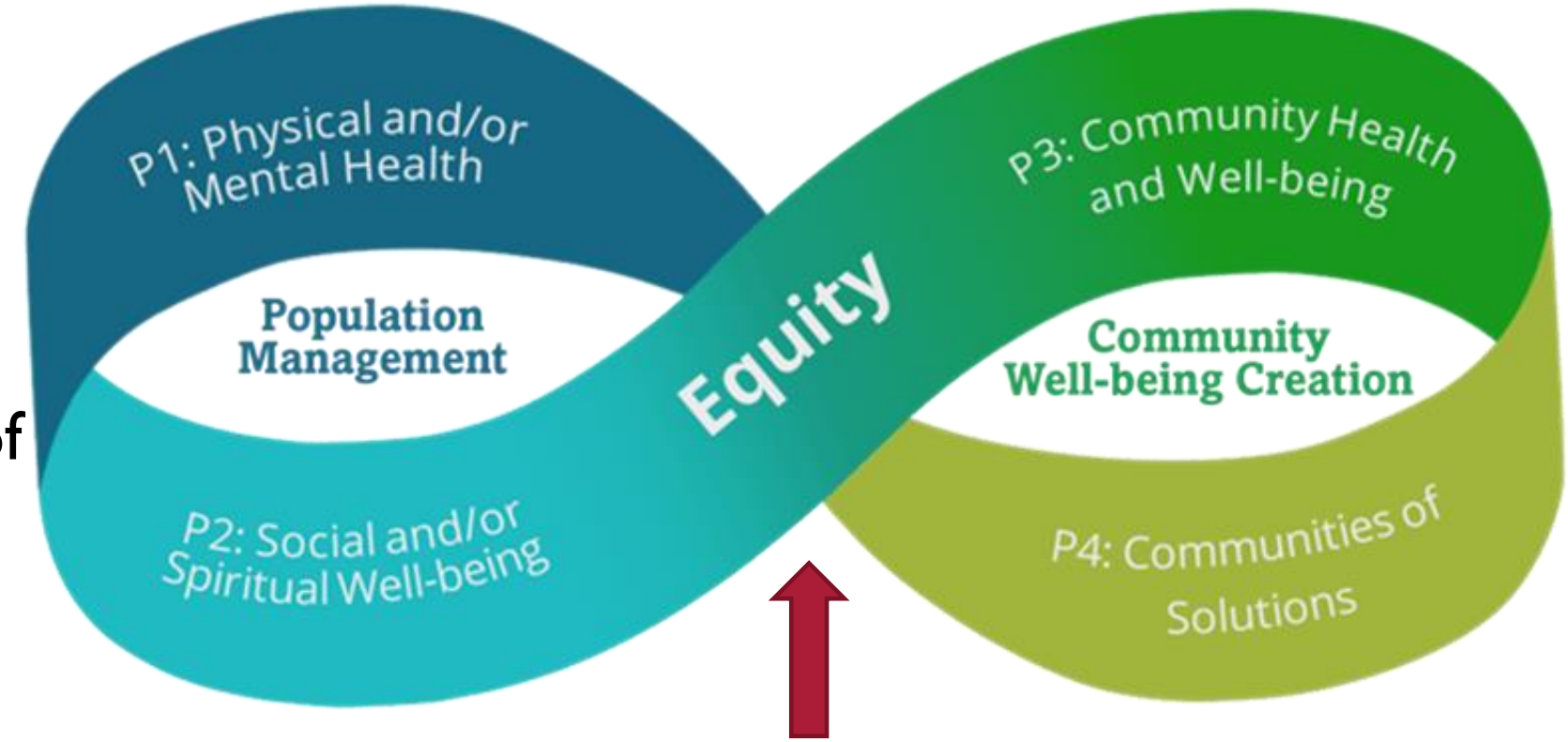



Improving the health and wellbeing of **places**

Improving the systems that drive (in)equity

Source: Pathways to Population Health, 2018

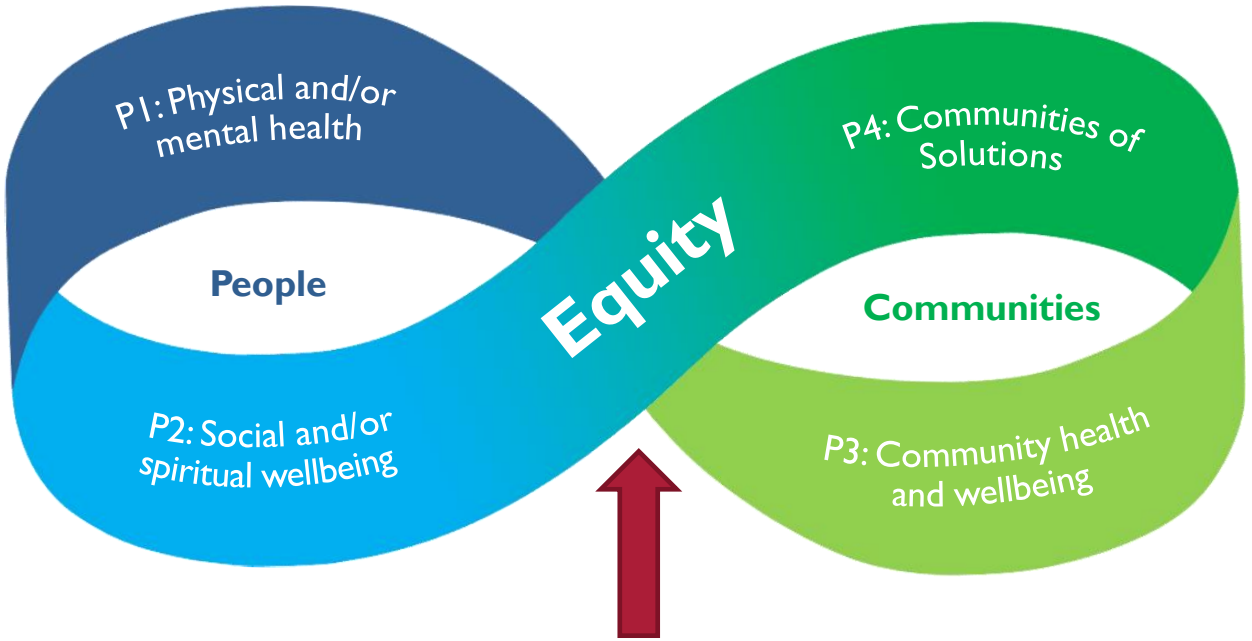
pathways2pophealth.org

# FROM CHARITY TO EQUITY TO LIBERATION: PATHWAYS TO HEALTH EQUITY

## Health, well-being and equity

Downstream (medical needs for people we reach)

Midstream (social needs for people we reach)




Groundwater – address root causes and legacies

Upstream- change underlying community conditions for SDOH

Improving the systems of society to "reverse the down escalator"

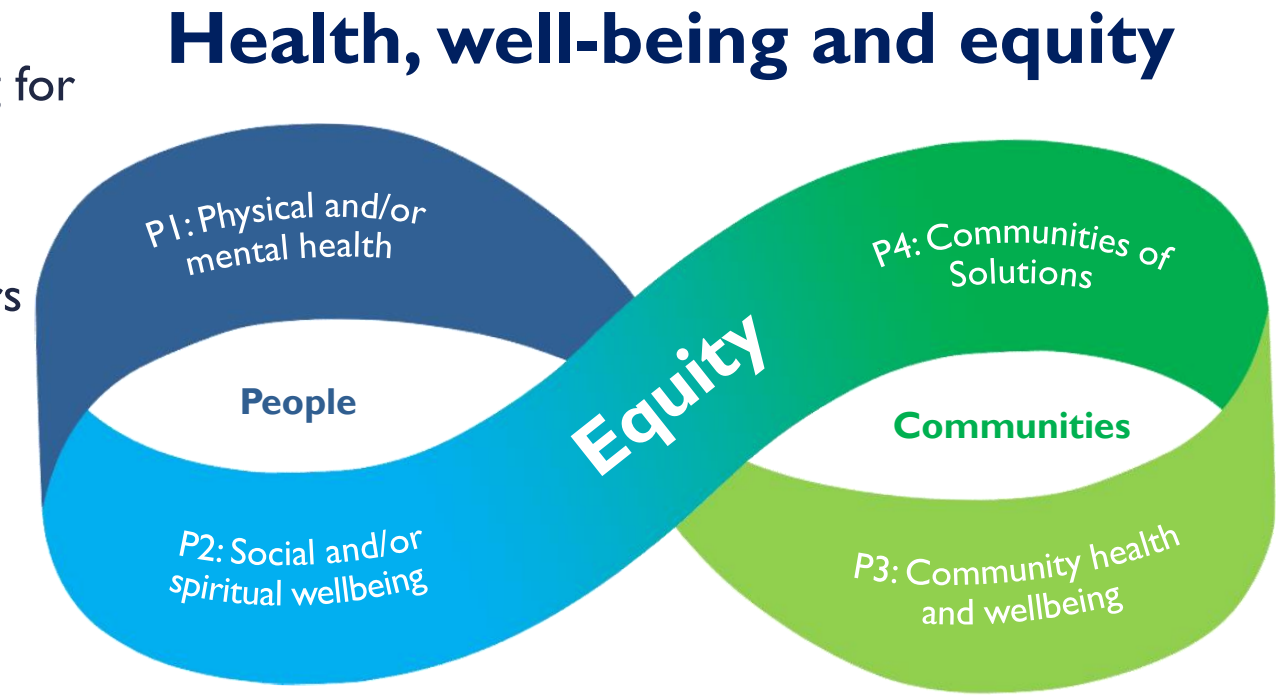
# FROM CHARITY TO EQUITY TO LIBERATION: PATHWAYS TO HEALTH EQUITY

## Downstream

- Screening for and caring for people with intimate partner violence
- Counselling for survivors
- Counselling for abusers

## Midstream

- Meet social and spiritual needs of violence survivors




## Groundwater

- Acknowledgement of historic harm
- Reclaiming of legacy → Family Wellness Warriors

## Upstream

- A recovery home with supports for survivors to thrive
- A trauma-informed and healing community – "Beauty to Ashes"
- Jobs available in the community as a pathway to hope

# CREATING A BALANCED PORTFOLIO, INCLUDING ONES THAT REVERSE THE ESCALATOR IN THE LONG RUN

- Providing food to those who are hungry
- Making it easy for everyone to afford and access healthy food

# P2PH COMPASS

- **Stewardship**
- **Equity**
- **Payment**
- **Partnerships with People with Lived Experience**
- **Portfolio 1:** Physical and/or Mental Health (Data, Team-Based Care, Behavioral Health Integration, Care Management)
- **Portfolio 2:** Social and/or Spiritual Well-Being (Data, Social Determinant Screening/Referrals)
- **Portfolio 3:** Community Health and Well-Being (Data, Community Partnerships, Community Benefit)
- **Portfolio 4:** Communities of Solutions (Data, Leveraging Nontraditional Roles, Policy)

# USING YOUR COMPASS SCORE TO DESIGN SYSTEM CHANGE

1. Look at where there is variation in your scores. Engage in a dialogue about why that might be.

2. Identify areas of strength and opportunities for improvement.

3. Develop an aim and a specific workplan for where you might want to be by the end of this initiative.

# THE RHODE TO EQUITY

# RI DIABETES HEALTH EQUITY CHALLENGE

Supporting the community during the COVID-19 pandemic

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# THANK YOU!

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