Bridging the Gap: Reducing Disparities in Diabetes Care **Communication Brief**

Marshall University & Mountain Comprehensive Health Corporation

RESEARCH REFLECTIONS

Rural Community Health Workers improved confidence, quality of life and care experience

Rural Community Health Workers improved blood sugar control

Rural Community Health Workers reduced hospitalizations

Marshall University established innovative care coordination program with payors

BACKGROUND

In two research articles, authors share how a community health worker (CHW) – led chronic care management program for patients who face medical and social barriers (*e.g.,* transportation, food access) improved clinical and patient-reported outcomes of patients with diabetes. Mountain Comprehensive Health Corporation (MCHC), a network of federally qualified health centers throughout rural Kentucky, developed a partnership with Marshall University, which had success supporting rural federally qualified health centers in leveraging Medicaid reimbursement for CHW services as part of the Merck Foundation initiative, *Bridging the Gap: Reducing Disparities in Diabetes Care*.

These rural Appalachian health centers required CHWs to be members of the community where they work and interact with patients with respect and empathy. Crespo et al. found that the CHW intervention significantly decreased blood sugar (*e.g.,* mean HbA1c reduction of 2.4% from 10.0% to 7.6%, and 60% patients with diabetes lowered their blood glucose between baseline and 6 to 12 months after enrollment). **Incorporating lay community members into chronic care management teams was critical in establishing a direct link between clinics and their community, supporting patient's medical, social, economic, and self-management needs.** In a subsequent study in a special supplement of the *Journal of General Internal Medicine*, Tanumihardjo et al. found patients with diabetes engaged with MCHC CHWs reported improvements in self-efficacy, confidence in managing diabetes during hyperglycemia or hypoglycemia, and confidence in diabetes not interfering with their lives. Blood sugar levels for patients engaged in the rural CHW model significantly decreased at 6-months (*e.g.,* mean HbA1c reduction of 0.53% from baseline levels of 8.91%) and there was a trend in improvement at 18-months (*e.g.,* mean HbA1c reduction of 0.26% from baseline).

KEY TAKEAWAYS

Incorporating CHWs into care management teams established a real connection between clinic and community settings. **Better clinical outcomes and reduced emergency and hospital visit rates convinced payers to collaborate with health centers to pilot CHW-based payment models. Better patient-reported outcome measures provided additional evidence for the value of this CHW-led chronic disease management model.**

Based on the following publications:

- Crespo R, Christiansen M, Tieman K, Wittberg R. An Emerging Model for Community Health Worker–Based Chronic Care Management for Patients With High Health Care Costs in Rural Appalachia. *Prev Chronic Dis.* 2020;17:190316. doi:10.5888/pcd17.190316
- Tanumihardjo JP, Eversole C, Zhu M, Gunter KE, Peek ME. Glycemic Control and Patient-Reported Outcomes Among Patients with Diabetes Engaged with Community Health Workers in Rural Settings. *J Gen Intern Med.* 2023; doi:10.1007/s11606-022-07929-z