MERCK FOUNDATION

BRIDGING THE GAP
REDUCING DISPARITIES IN DIABETES CARE

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

Trenton Health Team

RESEARCH REFLECTIONS

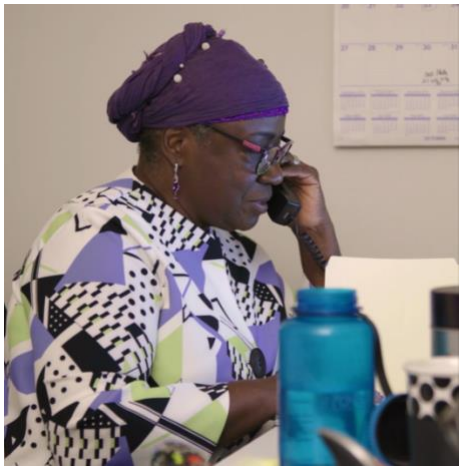
Collaboration was critical in establishing community health workers within medical care models

Innovative care models and partnerships integrated support for unmet social needs

Engaged with state agencies to advocate for improved reimbursement for community health workers

Upfront funding supported innovative care models in resource constrained settings

BACKGROUND



One in every five U.S. adults (21%) is estimated to have type 2 diabetes by 2050, almost double the current levels (13% of U.S. adults). As part of the Merck Foundation initiative, *Bridging the Gap: Reducing Disparities in Diabetes Care*, **Trenton Health Team (THT), a non-profit public health collaborative and Regional Health Hub in New Jersey, developed a community-wide effort called the Capital City Diabetes Collaborative (CCDC) to support patients with diabetes and to improve health outcomes.** Trenton has a higher rate of type 2 diabetes and poverty than both the state of New Jersey and federal averages. Trenton residents are predominantly African American and Latina/o/x. THT is a trusted organization in their community that understands community needs and engages with groups across health care, social care organizations, and public health agencies. At the outset, THT held community listening dinners to better understand how they could partner in the community to improve diabetes care. They leverage data-driven efforts like risk stratification and a health information exchange to enhance their community health activities. Patients are identified by their risk stratification model and referred to THT for care management to address unmet medical and social needs. THT works with local providers and healthcare staff to improve patient-provider relationships, and standardizes patient education materials across health systems to improve continuity and accessibility of these materials. THT also established a diabetes education program (*Project Dulce*) as well as a community-wide clinical care coordination team that guides clinical engagement and provides guidance on community interventions. In a special supplement of the *Journal of General Internal Medicine,* Tanumihardjo et al. detail that **THT prioritzed efforts within three domains: Social, Healthcare, and Environmental. Strategies in each domain align with their community's and the CCDC's vision of improving diabetes outcomes and addressing gaps in resources.**

KEY TAKEAWAYS

The CCDC led to beneficial improvements in diabetes self-management (*e.g.,* 26% more *Project Dulce* participants followed a healthy eating plan), diabetes outcomes (*e.g.,* 18% more THT care management patients had an HbA1c<9%) and addressed unmet social and medical needs such as food insecurity and insurance coverage (*e.g.,* 89% of referrals were successfully completed). THT also collaborates across sectors to seek funding from philanthropic grants, state-level support and funding, and direct collaborations with payors to extend the services available to Medicaid beneficiaries. **THT provides a model for other public health-focused partnerships that aim to improve chronic disease management and address both immediate social needs and structural determinants of health.**

Based on the following publications:

- Tanumihardjo JP, Morganstern E, Gunter KE, Martinez A, Altschuler S, Towns C, Schwartz E, Hopkins K, Burnett J, Ricks-Stephen C. Community Health Collaborative Facilitates Health System and Community Change to Address Unmet Medical and Social Needs in New Jersey. *J Gen Intern Med.* 2023; doi:10.1007/s11606-022-07927-1
- Tanumihardjo JP, Gunter KE, Chin MH, Kraus RN, Smith RA, de Oliveira, L, Peek, ME. Integrating Technology and Human Capital to Address Social Needs: Lessons to Promote Health Equity in Diabetes Care. *J Health Care Poor Underserved*, 2021. 32(2), 241-261. doi:10.1353/hpu.2021.0061

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