

# Take the Diabetes Rhode Island Health Equity Challenge 2020

Addressing systemic inequities to improve health for  
people with diabetes, and **at risk for adverse  
outcomes from coronavirus**



# What is the Diabetes Health Equity Challenge about?

1. Building clinical-community linkages across primary care clinics and Health Equity Zones (CBOs) to improve population health for people with diabetes who have significant equity challenges, and who are at higher risk for coronavirus
2. Using Pathways to Population Health tools to map our assets across clinic and community contexts to identify opportunities for more strategic action
3. Using this moment of crisis to rapidly respond and learn to apply a population health approach to advancing health equity more broadly



# What is the Health Equity Challenge?



# Who is involved?

## Challenge Participant Team:

1. Primary care clinic leaders from Care + Community + Equity (CCE) practices
2. Health Equity Zone\* public health & community leaders
3. Community health team members
4. Community residents with lived experience of inequities with diabetes

## Challenge Facilitators:

- Care Transformation Collaborative of Rhode Island
- Rhode Island Department of Health
- 100 Million Healthier Lives & WE in the World who helped develop the Pathways to Population Health tools

\* if geographic location has no HEZ, clinic leaders could partner with community based organizations



# Proposed Key Dates

- **Applications open: April 1, 2020**
- **Applications due: April 15, 2020**
- **Remote training\*: April 30, 2020**

(\*4 hours : 4/30; 2 hours 5/14; 2 hours 5/28)

- **Funding recipients announced and receive coaching for next steps**

- **Second in-person\* session: June 19, 2020**
- **Final in-person\* session: September 18, 2020**

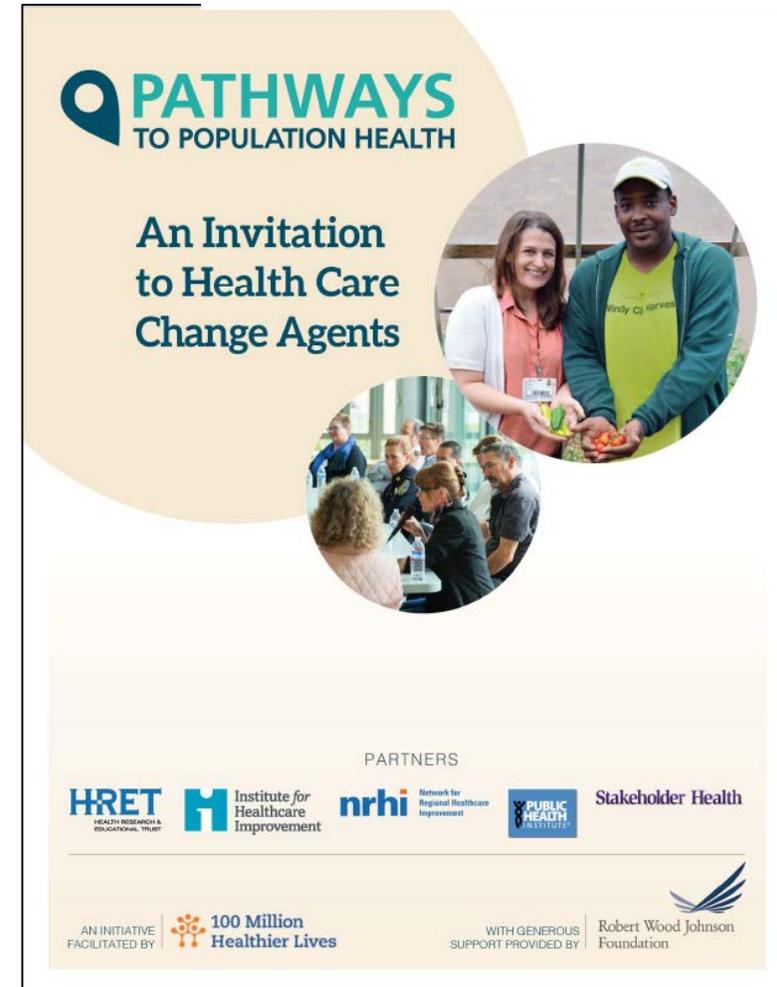
\*may be scheduled remote

# Pathways to Population Health

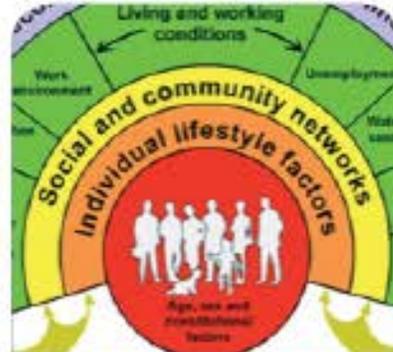


Tools developed by 100+ health care and public health organizations and adopted by 250+ stakeholders

Useful in aligning assets to advance population and community health with an equity lens



# Six Foundational Concepts of Population Health Improvement



1

Health and well-being develop over a lifetime.

2

Social determinants drive health and well-being outcomes throughout the life course.

3

Place is a determinant of health, well-being, and equity.

4

The health system needs to address the key demographic shifts of our time.

5

The health system can embrace innovative financial models and deploy existing assets for greater value.

6

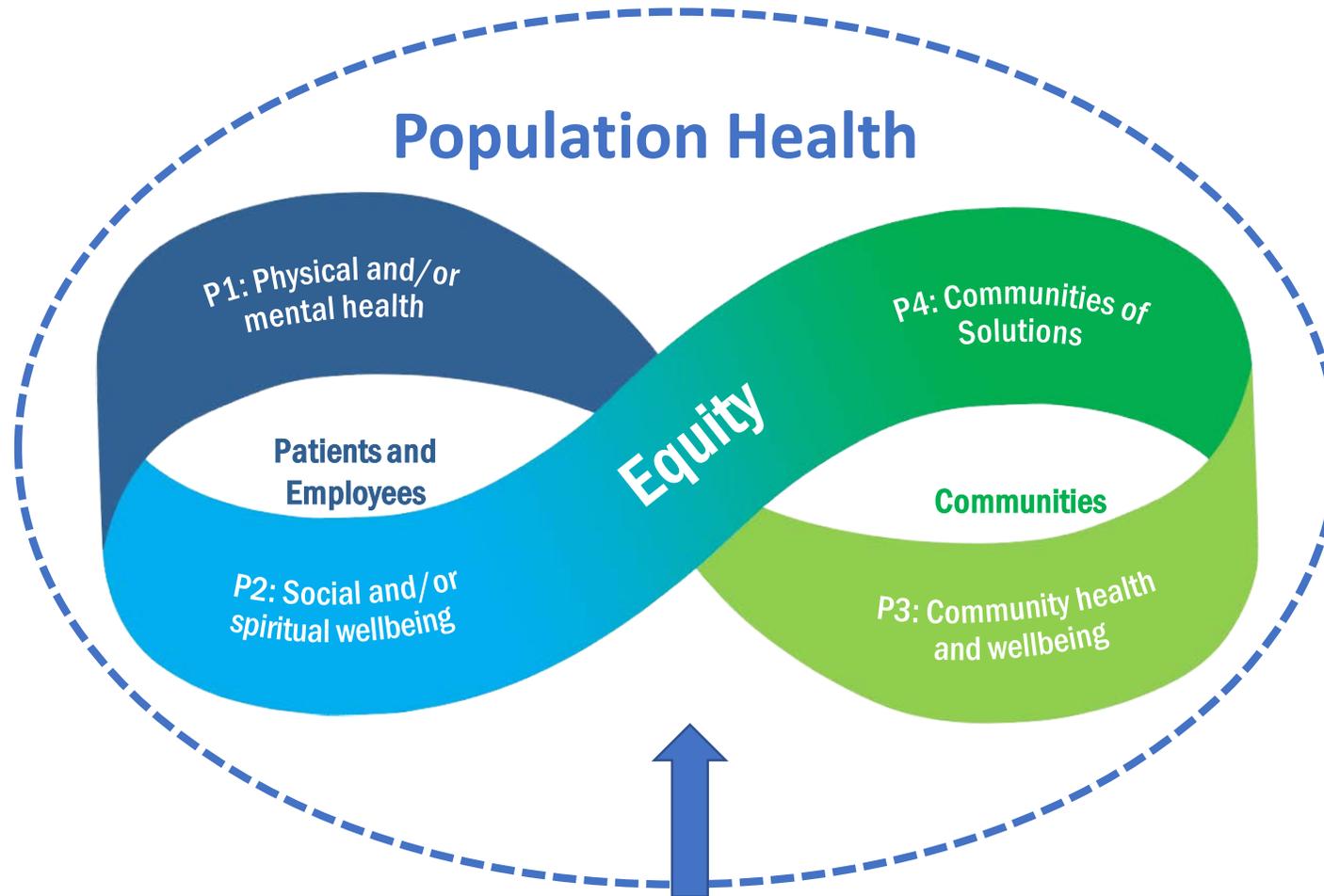
Health creation requires partnership because health care only holds a part of the puzzle.

What creates health?

How can health care engage?

# Pathways to Population Health: 4 Interconnected Portfolios of Work

Improving  
the health  
and  
wellbeing  
of people



Improving  
the health  
and  
wellbeing  
of places



WELL BEING  
IN THE NATION  
NETWORK

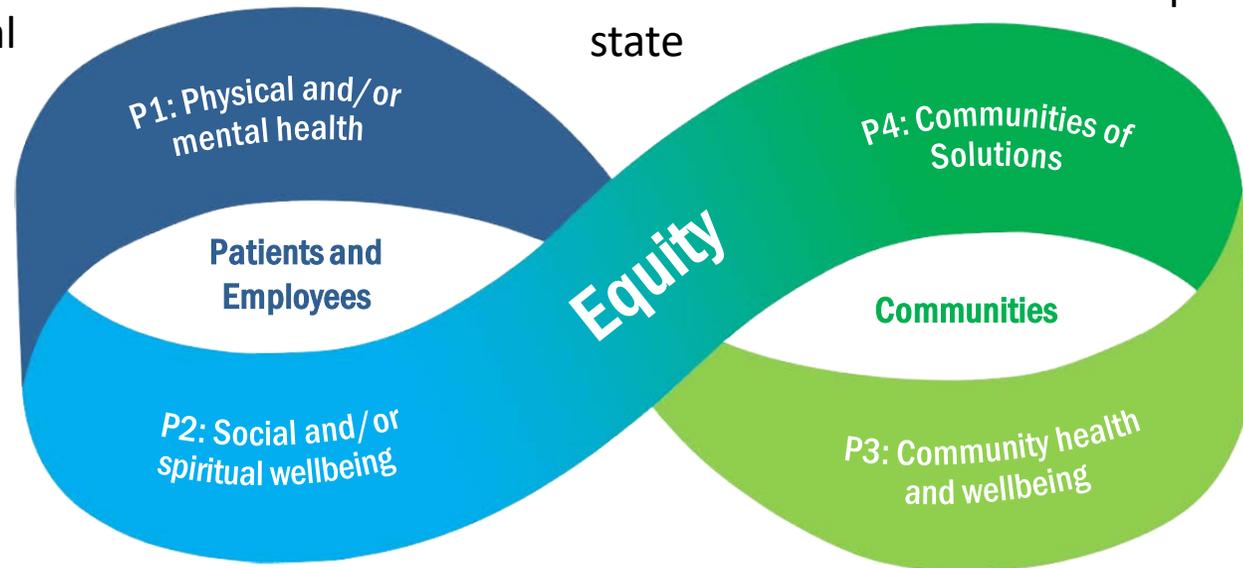
Improving the systems of society



# Applying this in the context of COVID-19

- Stratifying the population with diabetes in terms of COVID-19 risk, diabetes/physical health risk, mental health risk and social risk
- Access to medications, BG monitoring, supplies
- Telehealth services for physical and mental health (and reimbursement)
- Understanding who might have lost access to health and health care benefits as a result of loss of employment
- Loss of access to caregivers as a result of physical distancing
- Social isolation, loss of purpose
- Access to food, transportation, etc

- Advancing policies today that will help in the long run as well (paid family leave, living wages, etc)
- Sharing assets and investments to meet the needs of the most vulnerable people in the state



- Understanding how to connect initiatives and resources across the HEZ and leveraging them to meet the needs of people with diabetes and equity gaps



**WELL BEING  
IN THE NATION  
NETWORK**



# Opportunity for Care+Community+Equity Practices (CCE) to earn CCE Incentive Payments Based on Diabetes Health Equity Challenge participation

- Attend the March Best Practice Sharing meeting to learn more, apply to the Diabetes Health Equity Challenge, and be part of the 5-month learning collaborative

OR

- Attend the March Best Practice Sharing meeting and be part of the stakeholder engagement events that are held before June 29<sup>th</sup> 2020, which is the end of Year I contract



# Discussion

- Do you have the capacity to participate in a collaborative under the circumstances of COVID-19?
- Or, might you see the Diabetes Health Equity Challenge as a potential solution in assisting you with your work while also assisting the people in your community?
- We have thought about an approach being crisis management support *or* aftermath support. What are the +’s and –’s of each approach?
- How can clinics and HEZ prepare together to best respond to the challenges faced by patients/community members with diabetes now and over the next several months?
- Pain points for both clinics and HEZ finding ways to partner/support each other?
- Next steps
- Thank you for taking the time to join this webinar!



ADVANCING INTEGRATED HEALTHCARE

