Case Example: REACH U.S. Charleston and Georgetown Diabetes Coalition: A Community-Academic Coalition for Decreasing Diabetes Disparities in African Americans
Tell me about you and your profession—I am a……

A. Physician/ Health Care Provider
B. Behavioral therapist
C. Administration
D. APRN
E. RN
REACH: Charleston and Georgetown Diabetes Coalition

Statewide REACH home-based in Columbia:
- Welvista
- SC DHEC
- SC DPCP
Carolina Center for Medical Excellence

SC DHEC Region 6

SC DHEC Region 7

County Library

Enterprise Health Center
Enterprise Community

Trident Urban League

Alpha Kappa Alpha Sorority

Greater St. Peters

Charleston Diabetes Coalition

MUSC & VA MUHA Diabetes Initiative College of Nursing

Tennessee

North Carolina

Georgia

South Carolina

Georgetown

Georgetown Diabetes CORE Group

S. Santee St. James Senior Center

St. James Santee Health Center

East Cooper Community Outreach

Trident United Way

Trident Center Health

Franklin C. Fetter Family Health Center

Charleston County Library

County Library

South Carolina
Our Community Systems Wheel

Faith Based

How many of the systems from previous slides are you working with?

- A. None
- B. 2-3
- C. More than 3
- D. All
The Community Chronic Care Conceptual Model
REACH Charleston and Georgetown Diabetes Coalition

External Environment, Resources, and Dissemination influences:

Community Resource Systems
- Community Information System
- Community & Service System Design
- Community Decision Support
- Self-Management Support

Prepared, Proactive Community Systems

Prepared, Proactive Health Systems

Informed, Activated Persons

Policies & Actions Social, Health, & Economic

Improved Community-Wide Health Outcomes and Elimination of Health Disparities

Health Care Provider Systems
- Clinical Information System
- Delivery System Design
- Clinical Decision Support
- Patient Self-Management Support

Influences

(Jenkins, Pope, Magwood et al., PCHP 4 (1): 73)
Are you familiar with Chronic Care Model (Wagner)?

- A. Not at all
- B. I have seen it, but not used it
- C. I have used the model but am not clear about the component parts
- D. I am very familiar with the model
The Community Chronic Care Conceptual Model
REACH Charleston and Georgetown Diabetes Coalition

(1) Prepared, Proactive Health Systems
(2) Prepared, Proactive Community Systems
(3) Informed, Activated Persons
(4) Policies & Actions
(5) Social, Health, & Economic

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- Clinical Information System
- Delivery System Design
- Clinical Decision Support
- Patient Self-Management Support

Improved Community-Wide Health Outcomes and Elimination of Health Disparities

(Jenkins, Pope, Magwood et al., PCHP 4 (1): 73)
REACH Coalition as Integrator

Partner-level functions

- Recruit Coalition members and build trust within African American community
- Establish partnerships with groups that exert community influence
- Train and conduct comprehensive assessment of needs, “upstream” contributor to diabetes disparities, assets for addressing disparities.
- Establish governance, bylaws, funding, and goals
REACH Coalition as Integrator

Partner-level functions

- Enhance and strengthen community infrastructure and linkages (never replicate/compete)
- Select or develop/modify/test training materials
- Hire and train staff
  - Influential MD with diabetes expertise (consultant)
  - Community health workers (advocates/navigators)
  - Other—Administrative/financial management and data management/qualitative and quantitative evaluator(s)
- Add Coalition members and define contributions
Continuous learning and improvement

- Determine most efficient effective methods for capturing, analyzing, presenting, and tracking data over time to capture and track Coalition and staff activities, for improving care at individual, systems, community and county levels
- Verify/compare data with other sources
- Recognize successes quickly and look at systems for sustainability
REACH Coalition as Integrator

Continuous learning and improvement

- Evaluate and refine communication and feedback systems across multiple sectors with particular focus on those who can change or influence processes/outcomes
- Share succinct summaries with government and political decision-makers
- Share first with those most affected—particular community data—as members have stories to tell
REACH Coalition as Integrator

System-level functions

- Identify policy and practice changes for improving diabetes within and across systems—statewide guidelines and laws.
- Assess barriers/facilitators for policy changes, and developing processes to address barriers across multiple sectors-health systems, communities, families and individuals
- Translate/incorporate new research findings
- Scalability to other communities---Legacy Projects
REACH Coalition as Integrator

System-level functions—Sustainability

- Financial sustainability—specifically what are needed, how to generate, what needs sustaining
- REACH Coalition has Coalition in each county) that became 501(c)3 organizations that maintain community outreach and DSC provides “scientific expertise” while communities provide “community expertise” to DSC
- Leverage: Local funders, pooling resources, incorporate other health issues
Evaluation Logic Model

1. **Understanding Context, Causes, & Solutions for Health Disparity**
2. **Coalition**
3. **Planning & Capacity Building**
4. **Community Action Plan**
5. **Targeted REACH Action**
6. **Existing Activities**
7. **Community & Systems Change**
8. **Change Agents Change**
9. **Widespread Change in Risk/Protective Behaviors**
10. **Reduced Health Disparity**
11. **Other Outcomes**

**External Influences**

- **Change**
- **Other Outcomes**
Working effectively with communities moves the science from Bench to Bedside to Countryside more rapidly.
Community and Media Activities reached >125,000 African Americans

Skill-Building for CHAs and Volunteers

Community Screening and Education

Neighborhood Walk and Talk Groups

Individual/Group Education

≥ 3 sessions = 3.2% drop in A1c

Photos used with permission of clients and partners
Georgetown County Diabetes
Core Activities

Physical Activity

Health Screenings

Walk-A-Thon

Educational Classes
Healthy Cooking
Gardening Class

Dinner Theater

Gardening
REACH at the Library

Cybermobile
Equipped with 6 Internet laptop

MUSC
College of Nursing
Diabetes is a disease that affects millions of Americans every year.
Womanless Wedding

Men's Talk

Talk about Diabetes & Foot Care

Recognition and Rewards
### % Change in Diabetes Care for African Americans

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Charleston and Georgetown Counties LEA Rate per 1000 DM Hospitalizations

Data Source: SC Hospital Discharge Data, Office of Research and Statistics
Prepared by SCDHEC Office of Epidemiology and Evaluation updated 03/12
Preliminary Estimated Outcomes for Reduction in Diabetes LEAs in African Americans in 2 Counties

• Improved QOL for person whose legs were saved.
• Cost savings:
  – Costs per amputation in Georgetown County = $54,736 in 2008
  – Costs per amputation in Charleston County = $42,783 in 2008
  – Reduction in amputations compared to 1999 = 44% in African Americans
  – Cost savings of > $2 million/year.
Questions?
Other than behavioral problems, what is the major cause of disability and death?

A. Poor health care
B. Environmental exposure
C. Social circumstances
D. Genetic predisposition
Determinants of Health and Their Contribution to Premature Death

Proportional Contribution to Premature Death

- Behavioral patterns: 40%
- Genetic predisposition: 30%
- Social circumstances: 15%
- Environmental exposure: 5%
- Health care: 10%

Adapted from: McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21(2):78-93.
Across America, Differences in How Long and How Well We Live
Within States, Large Gaps in Life Expectancy

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*Due to multiple changes in county/census divisions, life expectancy for Alaska was estimated as a single figure, assigned to all counties in the state.

Growing Communities: Social Determinants, Behavior and Health

Our environments cultivate our communities and our communities nurture our health.

When inequities are high and community assets are low, health outcomes are worst.

Substance Abuse  Smoking  Violence  Stress
HIV/AIDS  Infant Mortality  Obesity  Depression
CVD  Nutrition

When inequities are low and community assets are high, health outcomes are better.

HIV/AIDS  CVD  Nutrition
Stress  Depression  Substance Abuse  Smoking
Obesity  Violence

Fragmented Systems  Powerlessness  Disinvestment  Disconnected Members

Adverse Living Conditions  Segregation  Income Inequality  Occupational Hazards  Institutional Racism
Unemployment  Discrimination

Quality Schools  Access to Healthy Foods  Access to Healthcare  Clean Environment  Transportation Resources
Adequate Income  Health Insurance  Quality Housing  Jobs

Sense of Community  Social Networks  Social Support  Participation  Leadership  Political Influence  Organizational Networks

SAFER • HEALTHIER • PEOPLE™

CDC™
As a Care Coordinator
Our Role is to Connect the Silos and Build Healthy Communities

Connect the Silos

- Medical Home
- Justice
- School
- Other Health Systems
- Basic Needs
- Social Services
What Next?

1. Identify high risk, high cost users and high prevalence, moderate cost users to identify strategies to improve quality of care and population health outcomes and costs of care.

2. Improve care coordination, promote prevention and reduce unnecessary utilization.
   – Person Centered Health Home with Navigator
   – Transdisciplinary team-based care
   – All providers operating at the “top of their license” and assisted through community change
3. Improve the health of population, via:
   – Measurable shared health outcomes for a geographic population, not just patients served
   – Coalition of multi-sector partners
   – Systems and organizational changes
     • Integrator to implement system level change
     • Shared learning process (QI collaborative) for change
   – Social marketing/health education campaigns
   – Training and technical assistance

4. Integrate and share data across multiple systems

5. Implement payment reforms for promoting health and disease prevention.
What might we do?

- Bring together health systems and providers, public health departments, multi-sector community-based partners, families and payers---No one model fits all, but make sure “vulnerable” at table.
- These consortia would demonstrate the potential to:
  - Rapidly design, develop and implement community change.
  - Contribute to the evidence base for population-based prevention.
- Participation in a collaborative learning process to facilitate sharing of best practices, testing out new ideas, including data for change, and shared problem solving.
- A design, innovation, technical assistance and support center would be charged with facilitating the collaborative learning, innovation and improvement efforts across all sites.
The Evolving Health Care System

The First Era (Yesterday)
- Focused on acute and infectious disease
- Germ Theory
- Short time frames
- Medical Care
- Insurance-based financing
- Reducing Deaths

Health System 1.0

The Second Era (Today)
- Increasing focus on chronic disease
- Multiple Risk Factors
- Longer time frames
- Chronic Disease Mgmt & Prevention
- Pre-paid benefits
- Prolonging Disability free Life

Health System 2.0

The Third Era (Tomorrow)
- Increasing focus on achieving optimal health
- Complex Systems - Life Course Pathways
- Lifespan/ generational
- Investing in population-based prevention
- Producing Optimal Health for All

Health System 3.0
“Everyone has the right to a standard of living adequate for the health and well being of himself and his family, including food, clothing, housing and medical care.”

*Universal Declaration of Human Rights 1948*
Acknowledgements

This project is funded by the REACH Charleston and Georgetown Diabetes Coalition CDC Grant/Cooperative Agreements U50/CCU422184 and 1U58DP001015 from the Centers for Disease Control and Prevention.

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- Charleston Diabetes Coalition
- AKA Sorority (N. Charleston)
- Greater St. Peter’s Church
- Diabetes Initiative of SC
- East Cooper Community Outreach
- Franklin C. Fetter Family Health Centers
- MUSC College of Medicine
- MUSC College of Nursing
- Georgetown Diabetes CORE Group
- MUSC Library
- SC DHEC Diabetes Prevention and Control Program and Epidemiology
- SC DHEC Region 7 and 8
- St James-Santee Family Health Center
- Tri-County Black Nurses Association
- Trident United Way 211 Help Line
- Trident Urban League
For additional information

Carolyn Jenkins, DrPH

e-mail: jenkinsc@musc.edu

Phone: 843-792-4625