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The Alliance to Reduce Disparities in Diabetes: Infusing Policy and System Change With Local Experience

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Abstract

This supplement provides a comprehensive and in-depth examination of proven clinical-community health strategies employed by the Alliance to Reduce Disparities in Diabetes, across five sites located in diverse geographic regions of the United States, including a tribal community. Alliance projects in these communities focused on African Americans, Hispanics/Latinos, and American Indians as priority populations. Each project was implemented with an understanding that there are cultural norms, community characteristics, and health care system challenges that require sustained multicomponent approaches to ameliorate factors that exacerbate poor disease management and health outcomes. The articles increase understanding of what is required to implement evidence-based approaches shaped by local experiences in order to meet the needs of diverse communities affected by diabetes. Lessons learned have generic elements that can be used in other priority populations and settings.

Keywords

chronic disease; diabetes; community intervention

Diabetes in the United States is a serious public health problem that disproportionately affects African Americans, Hispanics/Latinos, Asians, Pacific Islanders, American Indians, and Alaska Natives (Narayan, Williams, Cowie, & Gregg, 2011). Diabetes prevalence is 16.1% in American Indians and Alaska Natives (though rates are higher in some tribes), 8.4% in Asians, 11.8% in Hispanics/Latinos, and 12.6% in African Americans compared to 7.1% in non-Hispanic Whites (Centers for Disease Control and Prevention, 2011).

Historically, diabetes-related morbidity and mortality have remained higher among the previously listed racial and ethnic groups (Centers for Disease Control and Prevention,

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2011). The literature cites varied reasons for the disproportionate burden of diabetes among these racial and ethnic groups, which include family history, improper diet, limited physical activity, socioeconomic position, and limited access to high-quality health care (Agardh, Allebeck, Hallqvist, Moradi, & Sidorchuk, 2011; Knowler et al., 2002). The built and social environments often do not support access to places for safe physical activity and to healthy food options—these factors collectively affect risk for diabetes among racial and ethnic groups as well (Jack, Jack, & Hayes, 2012; Jack, Liburd, Spencer, & Airhihenbuwa, 2004).

Experts agree that to achieve sustained improvements in diabetes-related health outcomes, new strategies that go beyond individual- or patient-level approaches are needed (Jack et al., 2012). These new strategies will require an intentional focus on policy, systems, and environmental factors that contribute to health and well-being. Such strategies will also require a thorough understanding of the "lived experience" and the sociocultural contexts of populations and communities most affected by diabetes disparities. According to Glasgow, Lichtenstein, and Marcus (2003), "We need to embrace the complexity of the world, rather than attempting to ignore or reduce it by studying only isolated and often unrepresentative situations" (p. 1264). This is particularly true when seeking to improve health outcomes among vulnerable populations for which diabetes has exacted more significant costs—both financially and emotionally (Jack et al., 2012). Addressing diabetes among disparate populations will require (a) diverse stakeholders working together to identify underlying causes of diabetes disparities and (b) collaborative solutions that promote effective clinical–community linkages as a viable pathway to improving health.

THE ALLIANCE: AN INNOVATIVE AND DYNAMIC RESPONSE TO DIABETES DISPARITIES

Since its launch in 2009, the Alliance to Reduce Disparities in Diabetes (the Alliance) has supported, through funding from the Merck Foundation, the uptake of evidence-based and innovative practices to help reduce health disparities and inequalities among populations in five communities: Camden, New Jersey; Chicago, Illinois; Dallas, Texas; Memphis, Tennessee; and the Wind River Reservation, Wyoming. Alliance projects in these communities focus on African Americans, Hispanics/Latinos, and American Indians as priority populations. Each project was implemented with an understanding that there are cultural norms, community characteristics, and health care system challenges that require sustained multi-component approaches to ameliorate factors that exacerbate poor disease management and health outcomes.

According to Dr. Noreen Clark, Director of the Alliance's National Program Office until her death in 2013, "The Alliance's aim is to help decrease diabetes disparities and enhance the quality of health care by improving prevention and management services" (Clark et al., 2011). Over the past 5 years, the Alliance has worked with national, regional, and community partners to develop and implement comprehensive, evidence-based diabetes programs for low-income and underserved adult populations. Dr. Clark was very committed to the work of the Alliance, believing that it provides an excellent case study of what coalitions can do to improve processes of care. She was a major force behind designing the alliance model described below. She outlined the themes for the articles in this supplement to highlight the unique and compelling work in each community.

Table 1 describes the range of priority populations, community characteristics, project strengths, approaches, and contributions for each of the five funded Alliance projects. Each of the communities is applying the Alliance model designed to improve health care with the goal of reducing disparities in diabetes (Clark et al., 2011). The Alliance model is a multilevel strategy consisting of three core elements: (a) institutionalizing patient self-management education in targeted health facilities, (b) institutionalizing cultural awareness education for providers, and (c) modifying existing service delivery policies and procedures (or initiating new ones) to support provision of high-quality clinical care and enhanced clinician– patient communication (Clark et al., 2011). The Alliance model places emphasis on identifying innovative ways to promote the adoption of widespread and sustainable high-impact policy and system changes. Innovation in this instance goes beyond narrowly focusing on program delivery. The Alliance model enables its projects to (a) address underlying gaps and weaknesses in current health care systems and (b) identify system and policy changes critical to improving clinical outcomes within the sociocultural contexts of disadvantaged communities.

THE POWER OF POLICY AND SYSTEM CHANGE: LESSONS LEARNED FROM FIVE COMMUNITIES

The purpose of this supplement is to expand the literature by providing a comprehensive and in-depth examination of proven clinical–community health strategies employed across the five Alliance sites located in diverse geographic regions of the United States, including a tribal community. The important lessons learned and shared in this supplement are organized into the following categories and summarized as follows:

- *Program implementation*: All of the Alliance communities successfully encouraged an understanding of the patients’ cultural perspectives to foster productive partnering between providers and patients (Jack, Liburd, Tucker, & Cockrell, 2014). Alliance communities provided insights into how they incorporated cultural and linguistic competence throughout the design and implementation of projects. For example, the Alliance communities employed cultural brokering as a successful intervention. Cultural brokering is a health care intervention through which the professional increasingly uses cultural and health science knowledge and skills to negotiate with the client and the health care system for an effective, beneficial health care plan (Wenger, 1995). A major principle of cultural competence involves working in conjunction with natural, informal supports and helping networks within diverse communities (Goode, 2001; Goode, Wells, & Rhee, 2009). The concept of cultural brokering exemplifies this principle and can bridge the gap between health care providers and the communities they serve (Goode & Sockalingam, 2004). Alliance communities employed community health workers who served on clinical care teams and visited patients’ homes to ensure optimal continuity and coordination of care through the practice of cultural brokering.

- *Building partnership to effect change*: Taking time early in the planning process to identify champions and engaging key stakeholders was essential. Alliance communities were successful in securing champions who strengthened clinical–community linkages, built trust for the respective Alliance projects, and established funding opportunities to support programmatic effort beyond the funding from the Merck Foundation. These champions facilitated partnerships among primary care, medical specialty providers, the community, and public health organizations to initiate and sustain innovative strategies in order to improve support systems and diabetes care for patients.
- *Evaluation*: Data sharing across the community health system and organizing data-driven services for high users of diabetes services emerged as effective interventions for improving care delivery. Data-driven services involves designing and implementing targeted, effective health care strategies based on transparent risk stratification and predictive modeling to identify the health risk and cost drivers of health care across any population to improve health care performance. Additionally, Alliance communities realized the value of program evaluation data to monitor program progress, assess program outcomes, and demonstrate program effectiveness to key stakeholders. Monitoring progress resulted in securing support for programmatic efforts and sustaining the most promising interventions.
- *Planning to ensure sustainability of promising strategies*: Alliance sites demonstrated the importance of planning early for sustainability, which entailed the identification of traditional and nontraditional partners committed to reaching mutual goals. Over time, Alliance communities have been able to respond to emerging trends in health care (e.g., new reimbursement mechanisms) and secure additional funding that helps sustain programmatic efforts.

The collaborative work discussed across the articles in this supplement offers guidance on what it takes to address myriad factors that systematically affect diabetes management in diverse communities across the United States. Closing the gap between services and support offered in clinics and communities across the five Alliance communities required a commitment of purpose and time: building coalitions that spanned the boundaries of those typically found in health care, establishing and nurturing trust, and sharing resources and data across clinic sites. The Alliance model remains in sharp contrast to traditional medical model approaches that often emphasize “blaming individuals” without acknowledging how attributes of the health care system and neighborhoods negatively affect health outcomes.

CONCLUSION

Alliance communities recognized early on that innovations in achieving systems and policy changes are more likely to occur when they evolve from their “on-the ground experience.” We believe the work reflected in this supplement offers a valuable contribution to the field of health education and health promotion. Collectively, the articles increase our understanding of what is required to implement evidence-based approaches shaped by local experiences to meet the needs of diverse communities affected by diabetes. Lessons learned have generic elements that can be used in other priority populations and settings. Readers of this supplement are encouraged to adopt many of the strategies and recommendations shared by the authors.

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TABLE 1

Alliance to Reduce Disparities in Diabetes: Overview of Projects

Project Name	*Priority Population*	*Community Characteristics*	*Strengths/Approach*	*Unique Contribution(s)*
Camden Citywide Diabetes Collaborative (Camden, New Jersey)	African American; Hispanic/Latino	High concentration of patients in 9 square miles Widespread economic and environmental hardship	Focus on "hot spotting" to identify "high utilizers" Specialized outreach teams Standardize d diabetes self-management education and shared visits Physician 1:1 education	Establishment of citywide health information exchange system Citywide accountable care organization
Improving Diabetes Care & Outcomes on the Southside of Chicago (Chicago, Illinois)	African American	Multiple challenges: limited access to healthy foods, safety concerns, mistrust of health care system Lengthy history of strong social and political activism	Culturally tailored patient diabetes education program Early focus on clinic/ practice redesign	Numerous, strong clinic-to-community linkages and collaborations Effective use of media High-level dissemination
Diabetes Equity Project (Dallas, Texas)	Hispanic/Latino	Language/health literacy barriers Patients' immigration/legal status may affect willingness to seek health care	Extensive physician volunteer organization Strong role for community health workers Enhanced patient tracking via custom web-based diabetes management system, DiaWEB[a]	Community health worker role institutionalized and expanded in local health care system
Diabetes for Life (Memphis, Tennessee)	African American	Church and faith-based groups are highly influential Health ministry model used to address variety of health issues	*Conversation Map*®[b] sessions featuring pictures and metaphors for group diabetes education Intensive case management and follow up Physician champion leadership Quality improvement process at clinic/ practice sites	Health ministry involves 100+ churches Collaboration across informal and formal systems of care in Memphis and Shelby County
Reducing Diabetes Disparities in American Indian Communities (Wind River Reservation, Wyoming)	American Indian: Eastern Shoshone/Northern Arapahoe Tribes	Limited employment and economic resources Limited access to healthy foods Residents dispersed over wide geographical area (3,000 square miles)	Emphasis on tailoring the patient education program to needs of the priority population Strong community support Highly collaborative team with strong cultural identity	Established county-wide diabetes coalition Increased collaboration between two tribes and the Indian Health Service

[a] A custom Health Insurance Portability and Accountability Act–compliant web-based diabetes management system created with Chiron Data Systems to enable community health workers and clinicians to record and monitor patients

[b] The U.S. Diabetes *Conversation Map*® program is a motivational, innovative, and interactive educational program developed in collaboration with the American Diabetes Association and sponsored by the Merck Journey for Control™ program. The centerpiece of each session is the 3 feet by 5 feet visual map featuring pictures and metaphors that engage patients and promote discussion and learning.