12/6/2022

Monday, November 21, 2022 2:46 PM

Meeting Subject: Diabetes Strategy Team Meeting - 12/6/2022
Meeting Date: 12/6/2022 11:00 AM
Location: Microsoft Teams Meeting
Link to Outlook Item: *click here*
Invitation Message
Participants

Attended By

Sheree Gatewood, Briana Wagner, Devonne Franklin, Mary White, Stephane Bertrand, Elise Bowman, Clara Gitau, Ken Gelula, Hameenat Adekoya, Crystal Pope

Group Meeting Norms

- When you join, please chat-in or say your name.
- State your name before speaking.
- Verbalize messages in chat.
- Speak for yourself only, using "I" statements: "I do not like…" instead of "we do not like…"
- Raise your hand to speak and use your camera when possible.
- Closed Captioning is available through Teams by clicking on More Actions and selecting "Turn on live captions".
- Meeting notes will be sent in pdf format at the end of each meeting.

Vision

An equitable, just, and well Baltimore where everyone has the opportunity to be healthy and to thrive.

Agenda

1. Feasibility of collaboration, how we might collaborate on outreach and targeting new patients
2. How we can track success of referrals made to diabetes education
3. Any other objectives or goals, that our work might possibly support
4. Follow up with Angela on a few items
    a. EMS flow
    b. Overview of the program for new partnerships/ referrals

Meeting Notes

CHRC Funding

Promoting Community Health Resources: Expanding Health Care Access and Advancing Health Equity

Our application:

Our social needs team will provide outreach to the community, screen and identify individual social needs, and provide navigation supports to find and connect to the resources they need to be healthy.

How to work with Diabetes Strategy LHIC:

Build in a screening question, to make a referral to diabetes self-management and education

Applications due 12/19/22; Funding begins around 3/1/23

- Addressing social determinants of health and chronic disease, reducing health disparities and uplifting

health equity
- Looking for new people who have not been reached
    - Provide outreach
    - Identify needs
    - Meet identified needs
        - Deploy community health workers to outreach people in neighborhoods with a higher prevalence of health disparities
- Collaboration between BCHD, food entities, health entities
- BCHD is currently screening for social needs, wants to continue/improve work + expand
    - Diabetes SDoH
    - Connect people to resources needed to prevent and manage diabetes
    - Adjust tool
        - More people-friendly
        - Meet more needs

<u>Emphasis on identifying social needs and referring</u>
The funding is contingent on tracking and confirming referrals.
We need to build a referral documentation process for social and medical needs.

<u>Regional Partnerships</u>
Existing partnerships between University of Maryland Medical Center, Johns Hopkins University, LifeBridge, Saint Agnes
Referral pathways for self-management and diagnosis of diabetes
Documented in EMR and CRISP

<u>Work with diabetes social determinants of health</u>
Exploring access to healthy food
Other social needs we could explore:
Education
Access to primary care
Access to housing
Mental health services
Utility assistance
Transportation

<u>MD Food Bank: Link to Feed</u>
Electronic, online database
Enroll neighbors served in the database to track pantry usage
See where resources are actually going
Partnership with MedStar, Good Samaritan, Harbor Hospital for FoodRX programming
- Specific to reversal and treatment of diabetes

University of Maryland Medical Center, Downtown Campus to meet with MD Food Bank to restart their pantry and determine social determinants of health to be addressed
Opportunities:
- Refer folks to MedStar programs
- Work in-house with residents and teams at UMMC
- Host a pantry in another location

Covered cost for all food in the network during COVID-19, funding is ending this month. Unable to add additional partnerships en masse, but able to add partnerships to strategic areas within the city.

<u>Connection to farmers markets that accept EBT and SNAP:</u>
LHIC Social Determinants of Health workgroup
- Work surrounding food access

- Still defining direction

Central Baltimore Partnership
Received a grant for place-based funding to improve health needs in low-income areas (Midway, Greenmount Ave, West Freemount, Barclay)
Advisory committee scheduled next Friday
- Recommending focus on improving food access
- All related to hypertension, diabetes, obesity, access to primary care
- Focusing on food has the most impact

Work in a limited area can inform work throughout Baltimore.

Whatever we do here, we share. Whatever we share, we learn from.

Social truth for this data:
Multiple sources of data
- Health department data workflow
    - Outreach
    - Social needs screening
    - Electronic screening with funnel from outreach to resource connection
- Link to Feed and FoodRX
- CBO programs

How do we want to find people who need to be linked to diabetes education?
DSMT:
- Self-management training program needs provider referral
- Diabetes prevention program can be self-referred

Outreach coordinator can work with self-referrals to:
- Encourage patient to reach out to their doctor
- Let them know about diabetes training program
- Reach out to the patient to discuss requirements, get consent to call primary care provider for referral
    - Physician concerns re: losing patient
    - If all goes well, the patient only has to show up.

Community Health Worker role:
Provide navigation + care coordination
Hone support and increase referrals
Makes it easier for patients to follow through
CHWs to be deployed in areas with a high prevalence of health disparities and risks, or with healthcare gaps. (This is subject to change based on input before being finalized.)
- Community Development Network of Maryland: The CDN convenes with community development organizations around the city. This could be used to connect CHWs and regional partnerships.
- Regional partnerships target specific zip codes based on need. Robust food access programs tied into diabetes programs target food deserts and communities with high occurrences of pre-diabetes and diabetes.
- Utilize CRISP data to pinpoint targeted hotspots within the city to deploy CHWs.

BCHD would find the overlap between regional partnerships and community data to most effectively deploy resources.

GLOW Meeting

Advisory committee on CBP project.
Participants: BCHD, MD Food Bank, Central Baltimore Partnership

MD Food Bank

Gretchen Derwitz (RPD for MD Food Bank for East Baltimore partnerships), Devonne Franklin (RPD for MD Food Bank for West Baltimore partnerships)

Next Meeting: 12/20/2022 at 11:00 a.m.

- Conversation re: Talking to MCOs and funding structures
- Health Department working on a community health profile data structure
    - Meeting with the Care Coordination workgroup to discuss
    - What health and social needs data would you like to see collected?
    - What value does this bring to you and the community at large?

Next Steps

- [ ] Elise - share BCHD social needs screening tool
- [ ] Elise - Follow up with Angela
- [ ] Elise + Mary - share grant proposal with Devonne prior to naming MD Food Bank
- [ ] Mary - share RFP in post-meeting newsletter
- [ ] Devonne - How can MD Food Bank track and resource use?
- [ ] Devonne - Check to see if MD Food Bank can be named within the grant proposal