Diabetes Agenda 6.20.23

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.
- All meetings will be recorded

Vision

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

Mission

To protect health, eliminate disparities, and enhance the well-being of everyone in our community through education, coordination, advocacy, and direct service delivery.

LHIC Purpose

- The coalition's purpose is to identify and address Baltimore City's most **pressing structural health disparities** by bringing together a **multisector group,** with representation from community, health, and government.
- Requires the **shared leadership** of healthcare, government, organizations, community members, and representatives from underserved communities.
- Each LHIC identifies **3 health priorities** and works to address through a diversity of perspectives, collaboration, and pooling resources.

Agenda

Goal: Reduce the prevalence of diabetes in Baltimore City

Related Activities	Today's Discussion	Notes and Next Steps
• Increase the number of partnerships btw. Community	• INTRODUCTIONS: from any new attendees. Please share:	Catherine Maybury – Horowitz Center. Can be a resource for materials development

and DPP/ DSM • Increase the number of referrals to these programs	name, organization, what you would like to get out of your participation, any shared goals, and what you would like to contribute. • Request for ** Note takers**	for the stakeholders in this meeting; written, oral, websites. Sam Zisow-McClean – Moveable Feast. At least 60% of population served has diabetes. Sonya Jones – Maryland Physicians Care, Social Worker. Looking to partner and collaborate with resources for members living in food deserts. Stephanie Archer-Smith – Meals on Wheels of Central MD. Provide meals to older adults who are homebound, participants often have diabetes. Have a diabetes menu. Next steps: Catherine, Sam, Sonya, and Stephanie want to collaborate.
• Increase the number of partnerships btw. Community and DPP/ DSM • Increase the number of referrals to these programs	• FOLLOW- UP: Engaging Community Members. Please share the flyer. • Invite a community member	Looking to recruit 12 community members • Interested in DPP • Not currently involved directly through work • Stipends are available - $30/hour through gift cards
• Increase the number of partnerships btw. Community and DPP/ DSM • Increase the number of referrals to these programs	• FOLLOW-UP: The AHA- DPP/ DMST partnerships. • Rhonda + AHA met with BCHD and Sheree (Life Bridge) and discussed scalable chef video • Opportunity to partner with community using BCHD mini grants • The Goal of the video series is create videos to be paired with DPP or other Diabetes classes	Rhonda: If anybody is willing to help query end users to see if a cooking class led by a chef would be beneficial. Will follow-up with dates for a 1.5 hour storyboard session. Crystal: meals that do not have to be cooked for older adults; homeless populations knowing what they can eat raw.

	to improve engagement and retention • Next Steps: AHA is scheduling a meeting with MedStar, UMMC, LifeBridge, JHU, and St. Agnes to story board the chef video	Next steps: AHA sending email with potential dates. BCHD will send invite out to group for storyboard meeting by mid-July. Crystal Parker, Sam, Alice Huang, Dr. Perry from Morgan State, Stephanie Archer-Smith
• Increase the number of partnerships btw. Community and DPP/ DSM • Increase the number of referrals to these programs	Engaging Older Adults • Follow-up from Quarterly Meeting and prior discussions on the need to engage with older adults, due to their high likelihood of diabetes • Recommendations from Alice Huang from BCHD who oversee the Senior Centers and previously oversaw Food Policy at the Dept. of Planning • Discussion: We have an opportunity to receive feedback from older adults through our community members. How do we want to engage with that feedback?	Senior housing and senior centers are different. Housing is where people live, centers are more like rec centers for older adults. Housing Authority has some buildings, a lot of others are managed by independent companies and management teams. Can work with HABC buildings. Can reach out to Alice about programs and schedule time to visit and present about program. July senior farmers market is an opportunity for members to table; chance to tell people about DPP and DSMT. Eating Together program orientation coming up. ~45 sites where meals are served, can schedule a five minute presentation to residential managers who often need to look for programming for residents. Crystal: had asked in the last meeting about level of engagement from support staff inside the housing complexes? Can older adults do DPP as a group in their community room to increase likelihood of completing yearlong program? Sheree: engages with senior housing service coordinators who have scheduled dates for team to visit and talk about DPP/DSMT SNAP (Alice): during COVID people received

		maximum allotments, process was easy, people receiving $150-200 per month. Emergency allotment has ended and original formula has been reinstated (e.g. $200 down to $26 per month). MD has a $40 minimum. Opportunity for food box, vouchers, incentives, etc to outreach to older adults about their services. Seniors are looking for something engaging, not a lecture or sit-down session. Crystal: seniors with disabilities may receive lower SNAP benefits than younger adults. Stephanie: screen and enroll participants for SNAP. Taking referrals for reauthorizations (not Meals on Wheels clients) and attempting to maximize their allotments. Residents will get a notice about reauth, call DHR, and DHR refers to Meals on Wheels. Sheree: not in contact with DPR yet. Alice: work with senior division of DPR. Next meeting: how can we act on the feedback we've received from residents through Alice? Hoping to have a new group of community members joining the meeting. Sorting out how to collaborate on CDC grant work. Kicking off CHNA.
• Increase the number of partnerships btw. Community and DPP/ DSM • Increase the number of referrals to these programs	Review+ Discussion: CDC Grant Update	

POTENTIAL Work Thru CDC Diabetes Grant **

<u>Note: NO AWARDS have been made. This is a Tentative Plan, being shared in anticipation of the funding announcement on June 30. IF BCHD receives the funds, we will move forward with this plan. This is informative only.</u>**

Goal	Target	Strategies	Is Work Group's Role(s)	Questions
Increase enrollment and retention by strategically outreaching to Black communities most at risk for developing type 2 diabetes.		-Convene a multisector group of CHWs, community members, diabetes providers, and community organizations to assess, refine, and continuously improve the quality of outreach, enrollment, and retention -Strategically deploy 5 CHWs into Community Statistical Areas (CSAs) or neighborhoods, starting with neighborhoods with highest percentage of households earning less than $25,000, and highest rates of diabetes prevalence to outreach door-to-door with education flyers and provide education and make diabetes prevention program referrals at community events -Collaborate with community organizations in neighborhoods most at risk for diabetes to provide educational materials, make referrals to Diabetes Prevention Programs, and host education and outreach events	- We can use this space or create a sub group, depending on competing priorities -This WG (or sub) can assess and refine thru regular reviews of data and feedback -HCAM will deploy CHWs, BCHD will build mapping tools, -BCHD will facilitate cross collaboration and improve engagement of the CBOs, -Cross collabor with organs in the SDoH group	Sonya: has been building relationships with small community orgs; willing to pass information to these orgs while meeting with them
Support the development of multi-directional e-referral systems that support electronic exchange of information between health	Build a bi-directional workflow between 1-2 Diabetes providers and 5-10 community organizations.	-Complete a Strengths-Weaknesses-Opportunities-Threats (SWOT) analysis and exploration of at least 3 technology options -Complete an analysis of existing barriers to bi-directional workflows	- BCHD + MDH+ CRISP+ Consultant will lead a SWOT -BCHD will facilitate -Existing Healthcare and community from this group will share barriers -Cross collab with Care	

care and CBOs		-Implement a community-based organization incentive program to support participation, technology changes, and reporting -Design and pilot bi-directional workflow -Develop an implementation plan for future scaling -Scale from 1 site to 10 community organizations by end of project	Coordination group to identify learning objectives + incentives plan -Cross collab to identify CBOs -Utilize CRISP or other tool, develop workflows --BCHD + consult will lead -This group will input	
Implement, spread, and sustain one of the following evidence-based, family-centered childhood obesity interventions, Mind, Exercise, Nutrition…Do It! (MEND).	Implement 8 annual sessions of the MEND program in Baltimore City.	-Explore and design the workflow, location, trainers, and process with BCPS, CHWs, community members, and diabetes providers -Recruit children and families to participate through school outreach, providers, and community outreach -Develop an implementation plan that can be shared for future implementations. -Implement incentives to support community locations to host trainings. -Educate at least 96 children each year on nutrition and exercise	-Develop sub group to explore, cross collab with sdoh, farmers, HCAM, -HCAM/BCHD lead -Roll out year 2 BCHD/MEND Trainers lead	
Improve Systems	Build and spread a	-Complete a needs assessment of diabetes	Led by BCHD + Policy	

that support CHWs in diabetes work	diabetes education curriculum, designed and built with the voice of community members, CHWS, and diabetes providers	training with the input of community members, CHWs, healthcare, and CBOs -Build a complete diabetes education curriculum for CHWs to increase their involvement in diabetes education -Spread the curriculum to 4 CHW associations and advocacy groups, CHW organizations, and local health department	consultant -Cross Coll with this WG + Care Coordination will input/ inform in collaboration -Developing CHW partnerships will be including in this work moving forward	
Improve Systems that support CHWs in diabetes work	Introduce one piece of legislation toward CHW reimbursement for outreach, education, and/or social needs screening.	Convene CHW advocacy and associations -Complete a SWOT analysis of the policy landscape -Build a policy strategy	-Led by BCHD + Policy consultant -Cross Coll with this WG + Care Coordination will input/ inform in collaboration -Developing CHW partnerships will be including in this work moving forward	

Next Steps

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