Alliance Policy Briefing Executive Summary
November 20, 2014

The Alliance to Reduce Disparities in Diabetes, supported by the Merck Foundation, convened a briefing on November 20, 2014 in Washington, DC to announce outcomes of an independent evaluation of the Alliance's five program sites. The briefing, "*Uniting Policy, Practice and System Change to Create Healthcare Systems That Work*," focused on the Alliance program strategies to improve quality and create patient-centered care to better address the needs of underserved populations. To learn more about these outcomes, click here to view video of the Alliance briefing. You can download the briefing presentation slides here.

Distinguished speakers and panelists included:

- **Jeffrey Levi, PhD,** Executive Director, Trust for America's Health *(Moderator)*
- **Gail Wilensky, PhD,** John M. Olin Senior Fellow, Project HOPE *(Opening Remarks)*
- **Jeffrey Brenner, MD,** Executive Director, Camden Coalition of Healthcare Providers
- **Marshall Chin, MD, MPH, FACP,** Richard Parrillo Family Professor of Healthcare Ethics, Department of Medicine, University of Chicago
- **Erin Kane, MD,** Family Medicine Doctor, Baylor Scott & White Health System
- **Megan Lewis, PhD,** Director, Patient & Family Engagement Research Program Center for Communication Science, RTI International
- **Craig Anderson,** Regional Network President – Northeast, UnitedHealth Group
- **Matt Salo,** Executive Director, National Association of Medicaid Directors

RTI International conducted the cross-site evaluation which revealed several insights and lessons that are applicable to programs working to improve care for individuals with chronic disease. Some highlights include:

- **Tailor Interventions to Local Culture, Needs and Resources**: Tailoring the content of interventions to the local culture, needs and resources of each site was critical. By also executing a three-fold focus on patient, clinician and system change, we improved health for program participants. By leveraging local resources, clinicians were able to help patients learn how to better care for themselves at home and how to follow-through on care plans between visits to the clinic.

- **Implement Multi-Level, Multi-Component Programs to Create Flexibility**: This includes more and better communication across members of the care team, relationship building and aligning the program with larger organizational and community values. These activities create the flexibility necessary for Alliance programs to respond to patient needs in the most efficient and effective way possible.

- **Institute Health Care Provider Training on Communication and Cultural Competency**: Alliance programs implemented training for providers on cultural competency, communications tactics and skills. As a result, providers became better at communicating and engaging with patients in ways that resonated and resulted in change.

- **Promote Sustainability by Implementing Three Key Tactics to Improve Care Coordination**: 1) Improve care coordination through clinic-community collaborations, 2) Utilize non-clinical members of the care team (e.g., community health workers) and 3) Share electronic health information so physicians can access case history and past tests. These three tactics allowed care teams to more effectively identify the individuals most in need of care and tailor interventions to their unique circumstances.

- **Empower Patients to Achieve Improved Health**: Empowering patients to take charge of their health by providing access to needed supports and addressing local needs and barriers, including those outside the clinical system, resulted in improved patient blood glucose levels and better adherence to diabetes self-management behaviors. For example, the team at the Alliance's Chicago program, "Improving Health Outcomes on the South Side of Chicago," worked with local businesses to provide patients with prescriptions for healthy foods and access to places to take part in physical activity. The Dallas program, located at Baylor Scott & White Health, involved community health workers, non-clinical members of the care team, who were charged with teaching patients self-management skills and following up with them at home to ensure the patients were able to keep up with care plans.

Results across the Alliance programs were positive, including:

- Across the board, **blood sugar levels improved significantly**. Patient-reported outcomes data indicated an elevated sense of well-being, greater confidence in managing diabetes, better self-care behaviors, and more resources and support from the health care team.
- **56 percent** of program participants **improved** in **following a healthy eating plan.**
- **42 percent improved** in participating in at least 30 minutes of **physical activity** the recommended number of times per week.
- **62 percent improved in testing their blood sugar** as recommended by a health care provider.