

**Merck Alliance to Reduce Disparities in Diabetes (USA-Public-Private)**  
**<http://www.alliancefordiabetes.org>**

**Section I: Summary**

Through its philanthropic foundation, Merck & Co., Inc. (Merck), a U.S.-based pharmaceutical company, has committed \$15 million through 2013 to establish a national public/private partnership, the Alliance to Reduce Disparities in Diabetes, to improve diabetes prevention and management, particularly in low-income, underserved populations. The goal of the Alliance is to utilize collaborative, community-based approaches to develop and implement evidence-based diabetes programs that will improve diabetes prevention, management, and education, engage stakeholders at the community, state, and national level, and help healthcare organizations decrease disparities in diabetes care. In February 2009, the Merck Foundation announced programs in five U.S. communities that will receive assistance from the Alliance. The University of Michigan's Center for Managing Chronic Disease will assist the Alliance in evaluating the impact of its programs and share findings to help improve diabetes prevention and management.

**Section II: Statement of Purpose**

The Alliance to Reduce Disparities in Diabetes is a public/private partnership that encourages evidence-based collaborative approaches to improve diabetes prevention and management and reduce disparities in diabetes care in underserved, at-risk populations. The guiding principles of the Alliance are based in part on Wagner's Chronic Care Model that emphasizes patient-centered care and communication while acknowledging the importance of community alliances in improving health outcomes. To this end, the Alliance promotes comprehensive, multi-faceted, community-based approaches and works to improve communication between patients and healthcare providers to improve diabetes prevention and management.

In February 2009 Merck announced Alliance program grants in five U.S. communities that serve low-income, underserved populations with a high prevalence of type 2 diabetes: Camden, New Jersey; Chicago, Illinois; Dallas, Texas; Fort Washakie, Wyoming; and Memphis, Tennessee. The approach of these programs focuses on three main target groups: patient, clinician, and system. Patients are targeted through education and empowerment to affect behavior change, clinicians are targeted to improve communication skills and increase understanding of working with diverse populations, and healthcare systems are targeted to implement clinical policies and practices that can reduce disparities in diabetes care. The five programs are outlined below.

*Camden Citywide Diabetes Collaborative*

From 2002 to 2007, total charges for diabetes-related visits to hospital emergency rooms in Camden exceeded \$1.2 billion. The city also experiences heavy over-utilization of emergency room and hospital services in general, with half of all residents visiting a hospital or ER in a one-year period. The Camden Coalition of Healthcare Providers works to improve healthcare for at-risk, chronically ill citizens in Camden. The Camden Citywide Diabetes Collaborative is a project of the Coalition that will build on the organization's existing relationships and structures to achieve citywide coordination of services for residents with diabetes.

The core elements of the Camden Citywide Diabetes Collaborative include:

- Improving the capacity of community-based primary care practices to effectively treat patients with diabetes. This will be done by helping ten practices receive national quality assurance certification as Patient-Centered Medical Homes and other diabetes-related certifications. The program will also help practices implement important diabetes management tools such as a diabetes registry, electronic health records, group diabetes visits, on-site nutrition and diabetes education, and patient support programs.
- Improving patient self-management by providing culturally appropriate, bilingual self-management programs that emphasize healthy lifestyles. The program will also implement a monthly cable access television series on diabetes self-management and will provide video and audio educational materials.
- Increasing the capacity of medical day programs to care for diabetes patients through monthly staff education, standardization of care, and implementation of a diabetes registry at medical day programs.
- Improve coordination of care through the development of standardized order sets for outpatient, emergency department, and hospital treatment of diabetes patients, and development of a citywide diabetes patient registry.

#### *Memphis Diabetes For Life Program*

Residents of Memphis, Tennessee experience a high incidence of diabetes, obesity, and behavioral risk factors, and mortality rates for diabetes, stroke, and heart disease among African Americans in the region are significantly higher than national averages. The Healthy Memphis Common Table (HMCT), a health improvement collaborative of community organizations, coalitions, and individuals, is implementing the Diabetes for Life program to address disparities in diabetes management and care in the region. The key goals of the Diabetes for Life program are:

- Develop a comprehensive approach to diabetes management that includes proven, evidence-based diabetes and chronic disease self-management program.
- Promote access to diet and programs and resources, such as nutritional counseling, peer support groups, and physical activities.

- Provide case management to diabetes patients and their families to help coordinate care and support and maintain lifestyle changes.
- Implement standard quality management and clinical improvement procedures at community clinics to ensure proper screening and treatment of patients with diabetes.
- Improve provider/patient communication through cultural competency training and opportunities for patient feedback.

Memphis Healthy Churches (MHC) is a community-based organization will lead outreach efforts for the program. MCH is a 100 member-church organization that trains volunteers in health education and helps connect high-risk persons with screening and other services.

#### *Dallas Diabetes Equity Project*

The Diabetes Equity Project (DEP) is led by the Baylor Health Care System (BHCS) and involves a broad coalition of provider and community partners. BHCS is a large non-profit healthcare provider in north Texas that works to improve healthcare access, quality, and outcomes. Like the Camden project, the Dallas Diabetes Equity Project takes a multi-faceted approach by targeting patients, clinicians, and healthcare systems. Key components of the DEP include:

- Implementation of a community-based disease management program led by certified community health workers in five Dallas-area community clinics.
- Cross-cultural and care strategy training opportunities for physicians who volunteer to see uninsured patients with diabetes, through Continuing Medical Education course offerings.
- Implementation of an electronic diabetes registry.

#### *Improving Diabetes Care and Outcomes in Chicago*

The University of Chicago is leading an initiative to improve diabetes care and outcomes for citizens living in the predominantly African-American South Side neighborhoods of Chicago. The program will coordinate a range of stakeholders, including community clinics, community-based organizations, and an academic medical center to provide a collaborative model program in six clinics. Key components of the program include:

- Increasing awareness of diabetes disparities and empowering the community to effectively address the problem.
- Identifying costs, barriers, and solutions to successfully implementing the program.
- Providing culturally appropriate educational materials for patients to improve communication with their providers.
- Providing cultural competency and behavioral change training to providers to improve patient communication and support lifestyle changes.

- Rethinking diabetes management at the clinic level by adding patient advocates, nurse care management, and enhanced community partnerships to improve outcomes.

#### *Reducing Diabetes Disparities in American Indian Communities*

Diabetes is the fourth leading cause of death among Native Americans on reservations in Montana and Wyoming. A partnership between two American Indian tribes, government agencies, and a non-profit research institute is being implemented on the Wind River Indian Reservation in Wyoming (where over 70% of individuals are overweight or obese) to improve diabetes prevention and management, improve the skills of providers, and strengthen the health system and community support system for Native Americans with diabetes. The core philosophy of the program is based on the Chronic Care Model and the Tribal Participatory Approach (supporting community involvement and protection of tribal interests). Key components include:

- Establishment of a Diabetes Working Group comprised of Tribal leaders, Tribal healthcare professionals and policymakers, Indian Health Service (IHS) providers and staff, and others.
- Integration of activities with existing IHS chronic care management initiatives and state diabetes programs.
- Community education on diabetes prevention, management, and lifestyle change.
- Extensive training for clinical staff on clinical and behavioral aspects of diabetes management.
- Cultural competency workshops for healthcare providers.
- Targeted education program and classes with intensive 6-month followup to promote and sustain proper self-management skills and lifestyle changes.

### **Section III: Outcomes**

The programs of Merck's Alliance to Reduce Disparities in Diabetes are all in the initial stages of implementation, however funding is being provided for five years which should allow opportunities for evaluation and assessment as the programs move forward. Certain key elements are evident in all of the programs, which reflect the Alliance's overall approach to improving diabetes prevention and management and decreasing disparities among populations at risk for the disease. Common elements include a three-prong approach targeting patients, providers, and healthcare systems; maximizing community-based resources through coalitions and collaborations; use of technology tools such as electronic medical records and diabetes registries; emphasis on culturally appropriate materials and cultural competency training for clinicians; and improved communication between providers and patients to create and sustain improvements in diabetes prevention, self-management, and lifestyle changes.

#### **Section IV: Additional Resources**

Alliance to Reduce Disparities in Diabetes, "Alliance Fact Sheet,"  
<http://www.merck.com/corporate-responsibility/docs/access/AllianceFACTSHEET.pdf>.

Alliance to Reduce Disparities in Diabetes, "Disparities in Diabetes Prevention and Care," <http://www.merck.com/corporate-responsibility/docs/access/DisparitiesFACTSHEET.pdf>.

Alliance to Reduce Disparities in Diabetes, "Grantees Fact Sheet,"  
<http://www.merck.com/corporate-responsibility/docs/access/GranteesFACTSHEET.pdf>.

Institute for Healthcare Improvement, Chronic care model,  
<http://www.ihl.org/IHI/Topics/ChronicConditions/>.