Medical Xpress

Bridging the gap: Addressing medical and social needs improves diabetes care and outcomes

March 29 2023, by Alison Caldwell

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Nearly one in five American adults has diabetes. But that doesn't mean the common condition is simple to treat or manage. Diabetes and its

complications are the No. 1 cause of kidney failure, adult blindness, and lower-limb amputations. It's also the seventh-leading cause of death in the U.S. As with so many chronic conditions, diabetes also disproportionately affects the most vulnerable in our communities, further exacerbating existing health disparities.

In a new supplemental issue of the *Journal of General Internal Medicine* released March 28, physicians at the University of Chicago Medicine and colleagues nationwide are publishing the results of the Bridging the Gap: Reducing Disparities in Diabetes Care Initiative, a five-year multisite initiative aimed at addressing those disparities in diabetes care and outcomes across the country. Building holistic care systems to address individual medical and social care needs—along with policy changes that affect community resources and payment systems—can improve diabetes care and management, and improve health outcomes for many marginalized patient populations.

Now, as they report out the final outcomes of their five-year effort, the team is sharing what has been the most successful for improving outcomes. First, holistic, team-based care that bridges clinic treatment to community resources. This builds a trust-based relationship between clinicians and their patients and is tailored according to a patient's severity and needs.

Second, healthcare organizations that partner with community groups to address social factors such as food insecurity. This can expand care beyond the walls of a medical clinic and empower patients to better manage their own symptoms with community support. Finally, adjusting policy and payment systems to support and incentivize prevention and addressing unmet social needs like food access or housing improves outcomes. This reduces complications and improves overall care for patients.

Collaborators have built evidence-based holistic care systems to address diabetes care on a population level. This includes programs and partnerships to address challenges faced by marginalized communities that can increase risk of diabetes complications, such as access to healthy food and secure housing, in addition to addressing healthcare challenges for individual patients.

"Diabetes is a poster child for chronic illness," said Marshall Chin, MD, MPH, Richard Parrillo Family Distinguished Service Professor of Medicine at UChicago Medicine. "The principles we have identified and developed with this project apply to many other diseases, and could have a dramatic effect on population health and healthcare costs."

The cooperative system allowed healthcare organizations, community partners, public health leaders, researchers, clinicians and other healthcare professionals at the various institutions to work together toward shared solutions.

"This project has essentially been a learning collaborative," said Monica Peek, MD, MPH, MSc, Ellen H. Block Professor for Health Justice in the Department of Medicine. "Rather than the traditional funding model where a team would receive a grant and go off on their own to do the project, instead, we're doing everything we can to help the grantees succeed. We've provided coaching and organized group calls to share lessons learned and discuss challenges. Each site is working on the same problem but for their unique population in their unique region."

The group hopes these results and perspectives will inform ongoing and new initiatives to improve care access and diabetes management for patients nationwide. Already, they are seeing some rippling changes.

"When we started this project five years ago, many stakeholders weren't quite ready to make the leap to changes in the payment structure, and so

forth," said Chin. "But the COVID-19 pandemic has raised public awareness of health equity issues. We have a real window of opportunity to leverage our results and conversations to change policy, and we hope that these findings and lessons can guide those policies."

What has been key, the team says, is empowering the individual healthcare organizations to tailor their programs to the needs of their patients and recognize the importance of building personal, trusting relationships. "You can't just force a one-size-fits-all shortcut on this problem," Peek said. "You need to understand the local drivers and trust issues, and you need to combine the technical parts of the solution—like changing the payment system—with the cultural ones."

More information: Volume 38, supplement issue 1, March 2023 Bridging the Gap: Transforming Medical and Social Care for Diabetes, *Journal of General Internal Medicine* (2023). https://link.springer.com/journal/11606/volumes-and-issues/38-1/supplement

Provided by University of Chicago Medical Center

Citation: Bridging the gap: Addressing medical and social needs improves diabetes care and outcomes (2023, March 29) retrieved 6 May 2024 from https://medicalxpress.com/news/2023-03-bridging-gap-medical-social-diabetes.html

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