Partnering for Health Equity to Address Disparities in Diabetes Care, Management, and Prevention for Low-Income Latinx Immigrants.

Suyanna Linhales Barker, DrPH
Annie Sylvain, MPH
Angela Suarez, MD, MPH
Introduction

Our organization: La Clínica is a nonprofit, community-based organization and Federally Qualified Health Center (FQHC) committed to delivering high-quality, culturally and linguistically appropriate health services and education to the low-income Latinx immigrant community.

Target population/zip codes: Low-income, uninsured, underinsured, and Limited English Proficient (LEP) Latinxs in La Clinica’s Hyattsville Primary Care Center’s Service Area, primarily in Prince George’s County. Our top patient zip codes include 20783, 20782, 20737, 20784, 20786.

History serving the target population and community:

• Founded in 1983 in Washington, DC in response to the healthcare needs of a growing Latinx population displaced by civil wars.

• Focus on a culturally-competent, holistic approach to healthcare.

• Provide comprehensive health services in a co-located setting (primary, behavioral, and reproductive/sexual health) reducing barriers.

• Expanded physical presence in Prince George’s County from 2015 onwards:
  • School-based mental health program in Northwestern High School
  • Primary care clinic in Hyattsville
  • Expanded community outreach across Prince George’s County and with local partners, including Doctors Community Hospital (now Luminis Health)

• Providing diabetes prevention and self-management programs for 10+ years including CDC certification in DPP and Chronic Disease Self-Management certification (SMRC).
Specific Health Disparities

- **Specific health disparities the proposal will address:**
  - Disproportionate rates of diabetes and risk for diabetes among Latinx community:
    - 50% of Latinxs will develop Type 2 diabetes in their lifetime (CDC)
    - 16% of La Clínica's patients have diabetes.
    - 13.8% of adults in Prince George’s County have been clinically diagnosed with diabetes
    - 66.3% of Latinxs in Prince George’s County were overweight or obese in 2019, a risk factor for developing Type 2 diabetes.
  - Immigration Status
  - Lack of Health Insurance & Understanding of the US Healthcare System
  - Poverty and Food Insecurity
  - Language Barriers
  - Health Literacy

- **Key partners:**
  - Health care provider
  - Legal services provider
  - Food access provider
Interventions

Health inequities badly impact health outcomes for LEP low Income diabetic Latino immigrant community in Prince George County

- Provide culturally and linguistically appropriate care coordination for 180 LCDP high risk clients
- Access social needs and provide cross sectorial navigation as needed.
- Develop culturally and linguistically competent health literacy strategies and campaigns reaching 7,000 community member.
- Design and implement 3 advocacy activities to promote the importance of increasing access to primary healthcare for the low-income Latino immigrant.

LCDP and partners cultivate and advances health care system coordination

- LCDP and Ayuda and Farmer’s Market cultivate and advances cross-sectorial partnerships
- LCDP and Luminis disseminates a health literacy campaign on importance of primary care and prevention services and link clients as needed.
- Key Stakeholders participate and engage in ADVOCACY initiatives to fulfill needs of Latino immigrants

Health system care coordination enable the use primary and secondary care and prevention strategies (DMSE, walking groups) for Latinos to improve their health

- Cross sectorial partnership enable the use of resources for Latinos to improve their health
- Health Literacy campaign enable the use of primary care settings for Latinos to improve their health
- Public Health Policy is impacted for advocacy efforts that improve Latino Immigrant health

Low-income Latino immigrant community access local health system that fulfills their needs
Patient Enrollment Process

- **At the clinical level**
  - Risk stratification tool
  - Social determinants of health screening
  - Lifestyle screening

- **At the community level**
  - Glucose screening
  - Access to primary care provider
  - Linked to primary care provider *(unique identifier will be assigned if provider linkage is confirmed)*

- Community awareness interventions will not enroll patients, only track the reach of the awareness campaign

**Unique identifier:**

- Added to the EMR tracking care coordination, health education and referrals to specialty care, legal services and food access.

- Added to the internal data base tracking screening events and linkage to primary care providers.
Contact information

- Suyanna Linhaless Barker – sbarker@lcdp.org
- Annie Sylvain – asylvain@lcdp.org
- Angela Suarez – asuarez@lcdp.org