



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

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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 Clínica'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:

Luminis Health.	Health care provider
ayuda	Legal services provider
Crossroads Community Food Network	Food access provider



Interventions

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

Provide culturally and linguistically appropriate care coordination for 180 LCDP high risk clients



LCDP and partners cultivate and advances health care system coordination



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

Access social needs and provide cross sectorial navigation as needed.





Cross sectorial partnership enable the use of resources for Latinos to improve their health

Develop culturally and linguistically competent health literacy strategies and campaigns reaching 7,000 community member.

LCDP and Luminis disseminates a health literacy campaign on importance of primary care and prevention services and link clients as needed.

Health Literacy campaign enable the use of primary care settings for Latinos to improve their health

Design and implement 3
advocacy activities to
promote the importance of
increasing access to
primary healthcare for the
low-income Latino
immigrant.

Key Stakeholders
participate and
engage in ADVOCACY
initiatives to fulfill
needs of Latino
immigrants

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 determinate 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.







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