Name: Sujana Gunta MD, MS, FAAP
Professional Title, Organization: Director of Pediatrics and Site Director, Vista Community Clinic
CHIP title: Improving access to “Nutrition super-powers” in the era of obesity and chronic diseases

Project Description:
Chronic diseases (eg: heart disease, stroke, DM, kidney disease, cancer) account for 5 of the top 10 causes of death in our country. Obesity is a well-known risk factor for all these chronic diseases, and we have almost 40% of US adults and 20% of children obese in the US, and the COVID pandemic has only worsened these trends. We currently have outstanding innovations in the field of medicine that focus on medications, delivery methods, and surgeries, yet our communities continue to struggle with chronic disease management and increasing rates of obesity.

It couldn’t be emphasized enough that nutrition plays a major role in the prevention, risk reduction, and management of obesity and chronic diseases. Yet, healthcare models lack focus on it. My work is to highlight the power of nutrition in obesity and chronic disease prevention, risk reduction, and management in a model of integrated care.

The challenge was to create the nutrition-focused model in an FQHC (Federally Qualified Health Clinic) setting, with communities that are uninsured or underinsured, lack access to transportation, have limited means and income, rely on community health clinics for their comprehensive care, and all these barriers further muddled with insurance payment models failing to focus on prevention. The interviews with the stakeholders - patients and their caregivers, clinicians, leads from other departments, and healthcare leaders from other organizations to understand the needs of the community and the success/failures of previous efforts in this arena and community-based organizations - proved to be extremely vital in shaping the direction of this project.

Key findings and lessons learned:
- Listening to the community’s needs - individualized, culturally sensitive, affordable, and accessible care, focused on nutrition.
- Healthcare model built with a team approach between Nutritionist and Clinician, with support from other allied health professionals.
- Focus on sustainability- to create a meaningful, long-term impact in the community.
- Bridging connections to existing endeavors in the clinic - Training staff and clinicians on trauma-informed nutrition, continuing to build on work of Adverse Childhood Experiences and Trauma-informed Care.
- Understanding and leveraging barriers. An unforeseen barrier helped us create two nutrition-focused programs instead of one.

Outcome:
We have now created two Programs/Healthcare Models that focus on nutrition.
1. The Diabetes Mellitus (DM) Care Program has nutrition as a very intentional and integral part of the intervention; is up and running, successfully implemented at 3 sites, and has seen more than 90 patients as yet. It is focused on -comprehensive diabetes care- with a team of a Dietician, Nurse, Care coordinators, and Clinicians to serve the large population of >2000 patients with uncontrolled type 2 DM among our patients.
2. The Nutrition Wellness Program has the primary and focal intervention to be nutrition. It is focused on - improving chronic disease management (obesity/overweight or any chronic diseases) for the patient with improved nutritional choices- with a team of the Dietician and the Clinician. This program has secured funding and approval and is currently in the formative stages.

Both models provide individualized care, in the medical home of the patient and at no additional cost to the patient. The financial viability for the organization has been ensured with a model such that; these added services create additional visits that are billable in the traditional healthcare model, and by allowing the team members to work under their full scope, under the supervision of the clinician.

Next Steps:

- Implement the Nutrition Wellness Program at all sites.
- Partnership with Behavior Health Department within the organization to help patients with behavior changes associated with lifestyle management.
- Partnership with our Health Promotion Center, to provide resources to address food insecurity.
- Partnership with external organizations to provide medically tailored meals as an added means of chronic disease management.
- Harnessing the changes being considered with CalAIM and moving to value-based care.
- Short-termrm goals - focusing on the needs of the patients and the clinicians, ensuring financial viability.
- Long-termrm goals - Improved chronic disease management measured via improved metabolic measures, reduced related hospitalizations.